

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Sullivan Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 East Fourth Spokane, WA 99216	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to provide personal privacy for 2 of 2 sampled residents (Resident 5 and 8), reviewed for dignity. Failure to ensure the residents' personal privacy placed them at risk for lack of dignity and a diminished quality of life.</p> <p>Findings included .</p> <p><Resident 8></p> <p>In an interview on 08/15/2024 at 1:17 PM, Collateral Contact (CC) 1 stated when visitors came in to see Resident 8 they found the resident obviously soaked in urine on two separate occasions.</p> <p>Observation on 08/16/2024 at 12:42 PM showed Resident 8 was in bed covered with a blanket. Staff O, Physical Therapist, came into the resident's room and invited the resident to go to the therapy gym for a therapy session. Staff O pulled back the blankets which revealed Resident 8 was lying in a large puddle of fluid that was clearly visible on the front and back of their shirt and pants. A strong odor of urine was present. Staff O stated the resident needed assistance from nursing staff then went out into the hallway and immediately returned with a non-mechanical lift for transfers and assisted Resident 8 to transfer into their wheelchair. Staff O then took the resident, visibly soiled with urine, out of the room, down the hallway, and into the therapy gym, in full view of other residents, staff and visitors.</p> <p>At 1:04 PM the same day, Staff J and K, Nursing Assistants, brought Resident 8 back to their room and transferred the resident back into bed to change their clothing. Resident 8's clothes remained wet, and a large wet area was visible on the resident's wheelchair after they were no longer sitting in it. Staff J stated the resident should not have been taken out of the room in urine-soaked clothing.</p> <p>In an interview on 08/16/2024 at 4:52 PM Staff A, Administrator, and Staff B, Director of Nursing, confirmed Resident 8 should have received personal care before being removed from their room to maintain their dignity.</p> <p><Resident 5></p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 08/16/2024 at 1:29 PM showed Resident 5 arrived at the facility in a hospital gown, buckled on a stretcher, and accompanied by paramedics. The resident was taken to the hall they were admitting to, and the paramedics approached facility staff in the main area where Residents 1, 8, 9 and other unsampled residents were gathered and eating lunch. Staff M, Nursing Assistant, told the paramedics that the resident's room was not yet ready but did not offer a private area for the resident to wait.</p> <p>Continuous observations until 1:49 PM showed Resident 5 remained in the main gathering area of the hall on the stretcher with multiple paramedics accompanying them, while healthcare staff discussed the resident's admission in front of other residents and visitors in the area.</p> <p>In an interview on 09/04/2024 at 10:54 AM Resident 5 stated they were in a stretcher waiting for a long time in the main room when they first admitted to the facility, which they did not think was dignified.</p> <p>Reference (WAC) 388-97-0880(1)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to ensure allegations of potential misappropriation were reported immediately to administration and the State Agency as required, for 1 of 3 sampled residents (Resident 4) reviewed for abuse. This failure placed residents at risk for possible misappropriation.</p> <p>Findings included .</p> <p>Review of Resident 4's July 2024 progress notes showed an entry on 07/07/2024 by Staff H, Licensed Practical Nurse, which documented an allegation that Staff I, Registered Nurse, had misappropriated oxycodone (narcotic pain medication) from an unknown resident and administered it to Resident 4, due to lack of availability of Resident 4's medication from the pharmacy. The note showed Resident 4's pain was discussed with Staff B, Director of Nursing, but did not document whether Staff B was notified of the allegation of misappropriation.</p> <p>Review of the facility's Incident Log for July 2024 did not show any entries related to Resident 4 and/or any entries of misappropriation for any resident.</p> <p>In an interview on 09/04/2024 at 11:45 AM, Staff B, Director of Nursing, stated they were aware Resident 4 was having issues with pain on 07/07/2024 which resulted in them returning to the hospital. Staff B stated the facility typically reviewed resident progress notes and would investigate and report any allegations of abuse found in notes. Staff B reviewed the documentation present in Resident 4's progress note (see above) and stated they had not previously been notified of the allegation of misappropriation of an unknown resident's medication.</p> <p>Staff A, Administrator, was notified of the unreported allegation of misappropriation at 11:55 AM the same day.</p> <p>Please see F-697 for additional information.</p> <p>Reference: (WAC) 388-97-0640 (5)(a)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 of 3 sampled residents (Resident 8 and 12), reviewed for meal intake, received assistance setting up their meals and continued supervision and cueing while eating. This failure placed the residents at risk of decreased dietary intake, potential weight loss, and decreased quality of life. Additionally, the facility failed to ensure 3 of 3 sampled residents (Resident 8, 1, and 5), reviewed for bathing, received the assistance they required with baths and/or showers. This failure placed the residents at risk for skin breakdown, discomfort, and diminished quality of life.</p> <p>Findings included</p> <p><Resident 8></p> <p>Review of the admission assessment dated [DATE] showed Resident 8 had impairments to upper and lower extremities and was dependent on staff for activities of daily living (ADLs) such as eating, transferring and bathing. Per the assessment, the resident did not refuse care.</p> <p>Review of the care plan dated 08/09/2024 showed staff were to provide supervision and verbal cues to Resident 8 while eating. Per the care plan staff were to offer supplements/alternate for meal intake of less than 50% (percent). Additionally, the staff were to provide total assistance of two staff for bathing twice weekly, on Tuesday and Friday.</p> <p>In an interview on 08/08/2024 at 11:04 AM Collateral Contact (CC) 1 stated on 08/06/2024 Resident 8 was provided a meal tray with no assistance or encouragement from staff and when the resident didn't eat, staff removed the tray. Per CC1 on 08/07/2024 around 2:00 PM Resident 8 was lying in bed with food all over their face, blankets, sheets and pillows and unidentified staff reported the resident had spilled their food so was assisted back into bed (without replacing the meal). CC1 stated Resident 8 was not receiving the assistance they needed with many ADLs including eating, toileting assistance and hygiene.</p> <p>Continuous observation on 08/16/2024 from 1:24 PM to 2:09 PM showed multiple residents, including Resident 8, were seated at the tables in the communal area on the 100 hall for lunch service. An unopened cart with residents' meal trays was in the hallway nearby. At 1:33 PM Collateral Contact (CC) 2 asked Staff G, Licensed Practical Nurse, for Resident 8's tray. At 1:38 PM Staff G set the resident's tray down on the table and uncovered the plate before returning to the cart to distribute additional resident trays. Staff G did not provide cues for eating and all additional set-up assistance (cutting of meat, opening condiments, taking lids off beverages and sides) was provided by CC2.</p> <p>In an interview at 2:12 PM the same day, Staff K, Nursing Assistant, stated they did not have enough staff to provide assistance to residents in their rooms and residents eating their meals in the communal area at the same time. Staff K stated sometimes they did not have enough staff to get Resident 8 up out of bed for a meal and their family supervised their meals in bed.</p> <p>Review of Resident 8's August and September 2024 bathing records showed no documentation from their admission on 08/06/2024 until 08/24/2024 (18 days).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An undated written statement by Staff Q, Nursing Assistant, provided on 09/04/2024 showed Resident 8 required assistance of two staff for transfers into the shower and was dependent on staff assistance with showering. Per the written statement, Resident 8 was offered two showers a week and received one shower weekly and sometimes two if not refused.</p> <p>In an interview on 09/04/2024 at 3:34 PM Staff A, Administrator, confirmed documentation related to showers for Resident 8 did not show they were offered bathing assistance at the interval defined in the care plan (twice weekly). Staff A stated the assigned shower aide was on vacation but had provided a written statement that Resident 8 received one to two showers per week.</p> <p><Resident 12></p> <p>Review of the 06/05/2024 admission assessment showed Resident 12 had mobility impairments to one arm and required staff assistance for meal set-up.</p> <p>Review of the care plan dated 06/01/2024 showed the resident required supervision and verbal cues during the meal and staff were to check for pocketing (condition where food is held in the mouth without being swallowed). The care plan also showed the resident's nutrition was at risk and staff were to offer supplements and/or an alternative if meal intake was less than 50%.</p> <p>Continuous observation on 08/16/2024 from 1:24 PM to 2:09 PM showed multiple residents were gathered in the communal area on the 100 hall for lunch service. At 1:38 PM Staff G, Licensed Practical Nurse, brought Resident 12's meal tray out of the cart and set it down on a table, uncovered the plate, and walked away without uncovering/unwrapping the sides or beverages. Resident 12 was not yet seated at the table and once the resident arrived no staff checked with the resident to see if they needed any additional set-up assistance. At 1:47 PM Resident 12 was struggling to cut their main entree with one hand; after several failed attempts to cut the meat the resident stopped eating and sat at the table talking to other residents. Staff entered and left the area as they passed out meal trays or assisted other residents with care in their rooms, but no staff were monitoring the residents eating at the tables. At 1:57 PM Staff G asked Staff J and K, Nursing Assistants, if Resident 12 was done eating as they were no longer at the table but less than 25% of their meal had been consumed. Staff K stated the resident had left the hallway to go outside then picked up the resident's tray.</p> <p>At 3:18 PM the same day Resident 12 stated the meat on their lunch was too tough to cut and/or chew and they did not like the sides, so they did not eat that meal. The resident stated no one was around to ask for assistance or for an alternative, and staff did not come to the resident to offer an alternative. The resident stated they were concerned about their meal intake, specifically protein, because they had a wound on their bottom, but they didn't want to squawk.</p> <p><Resident 1></p> <p>Review of the 07/14/2024 admission assessment showed Resident 1 was severely cognitively impaired, did not refuse care, and required moderate assistance of one staff for bathing.</p> <p>Review of the care plan initiated 07/08/2024 showed Resident 1 preferred showers in the morning and staff were to provide extensive assistance with showers twice weekly, on Tuesday and Thursday.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the July, August and September 2024 bathing records for Resident 1 showed a gap of 13 days between showers on 07/24/2024 and 08/06/2024, and a gap of 22 days until the next offered shower on 08/28/2024, which the resident refused. There was no documentation a shower was offered after the resident refused on 08/28/2024 at the time of the record review on 09/04/2024 (7 days later).</p> <p>Interview on 08/13/2024 at 11:23 showed Resident 1 was confused and unable to provide details about their care. The resident smelled of urine though there was no visible wetness on their clothing and was unable to state when they were last offered/given a shower.</p> <p>An undated written statement by Staff Q, Nursing Assistant, provided on 09/04/2024 showed Resident 1 was offered two showers a week and will sometimes only take one due to giving themselves a sponge bath. The statement did not include information related to documentation of resident refusals or attempts to re-approach the resident after a refusal.</p> <p>In an interview on 09/04/2024 at 3:34 PM Staff A, Administrator, stated they spoke with Staff Q on the telephone as the staff member was not available that week. Per Staff A, Staff Q stated that Resident 1 received at least one shower a week and preferred to do the second one themselves. Staff A acknowledged that the bathing documentation did not match the resident's care plan and/or the staff member's statement.</p> <p><Resident 5></p> <p>Review of the 08/22/2024 admission assessment showed Resident 5 had paralysis to both legs and was dependent on staff for lower body dressing and hygiene. Per the assessment, the resident did not refused care and was not offered a shower during the assessment period due to safety concerns.</p> <p>Review of the care plan initiated 08/21/2024 showed Resident 5 required assistance of one staff for bathing and could have a shower or bed bath. Frequency of bathing was not defined.</p> <p>Review of the August and September 2024 bathing records on 09/04/2024 showed no showers and/or bed baths documented for Resident 5 (interval of 19 days since admission).</p> <p>In an interview on 09/03/2024 at 1:46 PM, Staff H, Licensed Practical Nurse, stated they were concerned for Resident 5's skin as they admitted with wounds and other skin impairments, but they were not receiving adequate bathing assistance. Staff H stated the resident did not receive a shower or bed bath in 10 days and attributed it to a lack of staffing.</p> <p>In an interview on 09/04/2024 at 10:54 AM Resident 5 stated they were at the facility for at least a week and a half before they got a bed bath, and they just had their hair washed for the first time the night before.</p> <p>In an interview at 2:04 PM the same day, Staff K, Nursing Assistant, stated the facility typically scheduled a shower aide in addition to the nursing staff assigned to the halls, but the shower aide was often pulled to the floor. Staff K stated there were many residents who required heavy/frequent care and staff struggled to find time to provide residents' showers if there was not a shower aide scheduled.</p> <p>See F-725 Sufficient Staffing for additional information.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reference: (WAC) 388-97-1060 (2)(c)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527</p> <p>Based on interview, and record review, the facility failed to ensure necessary wound care supplies were available and staff were knowledgeable in their use for 1 of 14 sampled residents (Resident 4), reviewed for quality of care. This failure placed residents at risk of not receiving necessary care and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the hospital discharge summary dated 07/05/2024 showed Resident 4 had multiple abdominal surgeries and discharged with two surgical drains (to remove fluid from a wound) to the abdomen. The resident was to discharge to a skilled nursing facility as they were not safe to return home.</p> <p>Per the 07/07/2024 skilled nursing facility transfer orders Resident 4 was to have negative pressure wound therapy (wound vacuum) to their abdominal incision continuously.</p> <p>Review of the July 2024 progress notes showed Resident 4 admitted to the facility on [DATE] with a specialty dressing intended for use with a wound vacuum but did not have a wound vacuum machine. Per the notes, the facility did not have the proper supplies available for the resident's care, and the resident was to be discharged back to the hospital later in the evening of the same day they admitted .</p> <p>In an interview on 08/09/2024 at 4:06 PM Collateral Contact (CC) 4 stated they asked both Staff I, Registered Nurse, and Staff H, Licensed Practical Nurse, about Resident 4's wound care on the day they admitted , but nothing was done. CC4 stated staff told them the facility did not have the supplies needed for the resident's wound care (wound vacuum) even though the facility had been notified of the resident's pending admission two days prior, on 07/05/2024. Per CC4, sometime after 10:00 PM Staff H came into the resident's room and told them the facility was discharging the resident back to the hospital because the facility did not receive records related to the resident's condition, and the facility could not provide necessary wound care and pain control.</p> <p>In an interview on 08/19/2024 at 2:32 PM Staff H stated Resident 4 admitted on a weekend and nursing staff did not receive training on how to deal with weekends admissions. Per Staff H, hospital records for Resident 4 were sent electronically to the nurse manager on duty and were not available for direct care staff to access on the day of the resident's admission. Staff H stated Resident 4 admitted with a specialty dressing for use with a wound vacuum, but was not connected to a wound vacuum machine, nor was one available in the facility. Staff H stated they asked Staff C, Resident Care Manager, and Staff F, Infection Preventionist, for guidance about the resident's wound dressing and was told the nurse managers would follow-up on Monday (the next day). Staff H stated after the resident had been in the facility for several hours a nurse from another hall (Staff I) came and told them to apply a wet-to-dry dressing to the resident's abdominal incision instead. Staff H stated Staff I refused to enter a new wound care order into the computer and Staff H did not feel comfortable writing and/or following an order they did not take from the provider.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 8), reviewed for accident hazards and staff supervision, were safely transferred with via the assistance devices and staff supervision level they were assessed to need. This placed the resident at risk for injury, decreased sense of safety and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the 08/13/2024 admission assessment showed Resident 8 had a diagnosis of hemiplegia (one sided paralysis or weakness) and was dependent upon staff for transfers.</p> <p>Review of the care plan initiated 08/06/2024 showed staff were to transfer Resident 8 via a total body mechanical lift and assistance of two staff. The care plan included that the resident had weak legs.</p> <p>In an interview on 08/15/2024 at 1:17 PM, Collateral Contact (CC) 1 stated an unidentified staff member transferred Resident 8 from their wheelchair into their bed with a mechanical sit-to-stand lift and no additional staff assistance. CC1 stated the resident had not been strapped into the lift properly and the straps to the back sling were up underneath their armpits, which caused them pain during and after the transfer. Per CC1 the staff placed the resident's right arm on the mechanical lift, but the resident did not have feeling in their arm and lost their grip. Additionally, CC1 stated the resident's right leg was not positioned properly on the transfer platform so all their weight was on their left leg.</p> <p>Observation on 08/16/2024 at 1:04 PM showed Staff J and K, Nursing Assistants, transferred Resident 8 from their wheelchair to their bed with the mechanical sit-to-stand lift. The staff strapped the resident's legs onto the transfer platform and placed a sling behind their back with the straps under the arms and attached to the arms of the lift. As the resident stood up with the lift, the straps dug into their armpits and their leg partially bent and came up off the platform. In an interview following the observation Staff K stated staff knew a resident's transfer status from their care plan on the computer, but the facility currently did not have computer access for a week due to a system change.</p> <p>At 1:49 PM the same day, Staff C, Resident Care Manager, stated resident care plans were printed and placed in a book at the nurse station prior during the computer downtime and that therapy staff and/or nurse managers would handwrite updates onto the care plan.</p> <p>In an interview at 3:08 PM Staff N, Nursing Assistant, stated they checked the resident's care plans prior to transfers and Resident 8 used a total body mechanical lift for transfers. Staff N stated they had been told the day before (08/15/2024) that the resident's transfer status had changed to the non-mechanical aid, but it was not yet written in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/16/2024 at 3:27 PM, Staff O, Physical Therapist, stated when Resident 8 initially admitted to the facility they required a total body mechanical lift for transfers. Staff O stated therapy staff had recently requested nursing staff use a non-mechanical stand aid for the resident's transfers, but if staff did not feel it was safe they could still use the total body mechanical lift for transfers. Staff P, Occupational Therapy, clarified that the resident was only to use the non-mechanical stand aid as the mechanical sit-to-stand lift was not safe for the resident due to their hemiplegia and the sling straps under the arms could injure the resident. Staff O agreed the mechanical sit-to-stand was not safe for Resident 8.</p> <p>In a follow-up interview with Staff C at 3:50 PM the same day Staff C confirmed therapy staff changed Resident 8's transfer status to a non-mechanical stand aid and the resident's care plan should have been updated to reflect the change. Staff C then reviewed the printed care plan at the nurse's station and stated it was incorrect (only the total body mechanical lift was listed for transfers). Staff C stated the total body mechanical lift was still an option if the resident was experiencing increased weakness at the time of the transfer, but the resident should not use the mechanical sit-to-stand lift as it was not safe for them with their weak legs. After further review of the resident's electronic and paper records, Staff C stated the resident's care plan had been updated electronically after the paper care plan was printed and staff did not have access to the current, correct information regarding the resident's transfers.</p> <p>Reference: (WAC) 388-97-1060 (3)(g)</p>

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NAME OF PROVIDER OR SUPPLIER Sullivan Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 East Fourth Spokane, WA 99216	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary pain management for 2 of 3 sampled residents (Resident 3 and 4), reviewed for pain. Resident 3 and 4 each experienced harm when the facility did not ensure they had the ordered pain medication, or another effective alternative, to treat the residents timely, which resulted in each resident requiring to transfer to the hospital to relieve their pain. This failure placed residents at risk of uncontrolled pain and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Controlled Substance Medication Orders, dated January 2023, showed a prescription required multiple components including a manual signature from the medical provider to be valid.</p> <p><Resident 3></p> <p>Review of the hospital discharge notes dated 07/26/2024 showed Resident 3 had pain to their right wrist, right groin, and right shoulder after a fall which resulted in fractures to the pelvis, rib and wrist. The resident was to discharge to a skilled nursing facility for physical and occupational therapy as they were not safe to discharge home.</p> <p>Per the 07/27/2024 hospital transition of care orders Resident 3 was ordered medications to treat pain: morphine instant release (IR) 15mg (milligrams) available every four hours as needed, and tramadol 50mg every six hours as needed. The hospital orders were electronically signed by the medical provider.</p> <p>Review of the July 2024 Medication Administration Record (MAR) showed neither of the medications listed above were administered to Resident 3.</p> <p>Review of the July 2024 progress notes showed Resident 3 admitted to the facility at 5:20 PM on 07/27/2024 and reported they had terrible pain that could become out of control quickly and was not relieved with tramadol. At 11:30 PM (six hours after the resident admitted to the facility) the resident called emergency medical services from their own cell phone to request transfer to the hospital for pain control. The notes showed the resident's documents listing the orders for pain medications were insufficient and most likely not sent to the pharmacy in time to allow for receipt from the automated medication dispensing system.</p> <p>In an interview on 08/09/2024 at 3:37 PM Resident 3 stated they admitted to the facility on a Saturday and were told that their medications would not be available from the pharmacy until the following Monday. The resident stated they reported pain to multiple staff and asked for their ordered pain medication at 8:00 PM and 10:30 PM, which they did not receive. Per Resident 3, when they notified staff they were calling emergency medical services for a transfer the staff offered a muscle relaxer, but it was not sufficient for pain control, and they had already been in pain for several hours.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 09/04/2024 at 10:15 AM Staff D, Resident Care Manager (RCM), stated the manager assigned on-call for the weekend was responsible for admission paperwork, including entering medication orders, but the orders could not be activated until the resident walked in the front door. Staff D stated on a weekday medication orders had to be submitted to the pharmacy by 5:00 PM for timely processing, but they were not sure what times medications had to be submitted on a weekend. Staff D stated Resident 3 arrived late in the day on 07/27/2024 and the prescription for Resident 3's morphine was not valid. Staff D stated they were trying to work with the hospital on fixing the prescription, but in the meantime the facility's medical providers would not write an authorization for residents that they hadn't seen.</p> <p>Observation at 11:06 AM the same day with Staff E, RCM, showed the facility had morphine IR 15mg available in the automated medication dispensing system. Staff E stated the morphine was stocked along with other commonly prescribed medications, but narcotic pain medication required pharmacy authorization to access.</p> <p>In an interview on 09/04/2024 at 11:20 AM Staff B, Director of Nursing, stated if there was a problem with the prescription from the hospital, the facility's medical provider was not comfortable writing a prescription, so the only option was to send the resident back to the hospital.</p> <p><Resident 4></p> <p>Review of the hospital discharge summary dated 07/05/2024 showed Resident 4 had multiple abdominal surgeries and discharged with two surgical drains (to remove fluid from a wound) to the abdomen. The resident was to discharge to a skilled nursing facility as they were not safe to return home.</p> <p>Per the 07/07/2024 skilled nursing facility transfer orders Resident 4 was ordered oxycodone 5mg one or two tablets every four hours as needed for pain and acetaminophen 650mg four times daily.</p> <p>Review of the July 2024 Medication Administration Record (MAR) showed the order for acetaminophen was not entered. Additional review showed no administration of the oxycodone.</p> <p>Review of the July 2024 progress notes showed Resident 4 admitted to the facility at 4:31 PM on 07/07/2024. No pain assessment on admission was documented. Per the notes, at 8:30 PM (four hours after admission) two facility nurses disagreed about the validity of the resident's oxycodone prescription as well as procedures to administer the oxycodone. The notes documented that the resident should be sent to the hospital for further care until their supplies and medications had been received or ordered.</p> <p>In an interview on 08/09/2024 at 4:06 PM Collateral Contact (CC) 4 stated nothing was done about Resident 4's pain until approximately 10:00 PM the night they admitted . Per CC4, Staff I, Registered Nurse, got permission from [the] supervisor to get one pain medication from the kiosk. CC4 stated about 10 minutes later Staff H, Licensed Practical Nurse, told them the facility was discharging the resident back to the hospital because the facility did not receive records related to the resident's condition, and the facility could not provide pain control and necessary wound care.</p> <p>In an interview on 08/09/2024 at 4:13 PM Resident 4 stated the staff at the facility had a nonchalant attitude about their pain. Resident 4 stated they reported pain to staff multiple times and were told the nurse would be right in but then they did not see a nurse until 10:00PM.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/19/2024 at 2:32 PM Staff H stated the pharmacy told them they would send Resident 4's medications, but the medications would not arrive until after 10:00 PM. Staff H stated Resident 4 did not complain of pain to them but they were told by Staff B, Director of Nursing, that other staff reported they had allowed the resident to suffer for six hours.</p> <p>Observation at 11:06 AM on 09/04/2024 with Staff E, RCM, showed the facility had oxycodone 5mg available in the automated medication dispensing system. Staff E stated the oxycodone was stocked along with other commonly prescribed medications, but narcotic pain medication required pharmacy authorization to access.</p> <p>In an interview on 09/04/2024 at 11:20 AM Staff B stated pain had been an issue for Resident 4 and Staff H reported that pain medication was not available due to an insurance issue with the pharmacy. Staff B stated upon investigation after the resident's discharge it was found that there were no issues with the pharmacy and pain medication was available in the facility, but Staff H did not have access to the automated medication dispensing system.</p> <p>See F-684 Quality of Care for additional information.</p> <p>Reference: WAC 388-97-1060(1)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to respond to call lights timely and to meet the care needs of 6 of 13 sampled residents (Residents 13, 8, 3, 4, 5, and 12), reviewed for sufficient nursing staff. This failure resulted in feelings of frustration and vulnerability, diminished quality of life and unmet care needs of the residents.</p> <p>Findings included .</p> <p><Resident 13></p> <p>Observation on 08/16/2024 at 12:25 PM showed Resident 13 was sitting in their wheelchair in the doorway of their room with the call light activated. The resident was looking up and down the hallway and muttering to themselves. At 12:56 PM the resident's call light was still activated and the resident wheeled themselves to the nurse's medication cart and asked when staff would be available to assist them into bed to use the bedpan. The resident stated they had been waiting more than 45 minutes and were beginning to become nauseous due to their gastrointestinal (GI) symptoms. Staff G, Licensed Practical Nurse (LPN), told Resident 13 that staff were busy moving a resident from one room to another. The resident replied, that doesn't help me. Staff G obtained Pepto Bismol (over-the counter medication used to treat various GI issues) at the resident's request then the resident wheeled back to their room.</p> <p>Further observation at 1:24 PM (an hour later) showed Resident 13's call light was still on and the resident was still waiting in their wheelchair for assistance with transferring and toileting. Collateral Contact (CC) 3 and the resident's roommate were in the room as well. Both confirmed the resident's call light had been on for more than an hour, and that residents often had to wait an hour or longer for assistance.</p> <p>In an interview at 1:26 PM the same day, Staff K, Nursing Assistant (NA), stated Resident 13 required the assistance of two staff members for transfers and they were waiting for Staff J, NA, to get the mechanical lift so they could assist the resident with their toileting needs. Staff K stated six out of the 18 residents residing on the 100 hall that day needed assistance of two staff for care and there were only two NA staff scheduled. Per Staff K, it was difficult to respond to resident requests timely and sometimes on the weekends staff would call off work and would not be replaced so Staff K was the only NA on the hall. Staff K stated the previous weekend they were not able to get Resident 13 up out of bed until after evening shift staff arrived at 2:00 PM because staff from the other halls were busy and unable to assist.</p> <p>Review of the facility staffing records from 08/06/2024 to 08/18/2024 showed the facility typically assigned two NAs and one nurse to each hall during the day and evening shifts with additional aides (shower aides and restorative aides) not assigned to a hall.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/16/2024 at 2:41 PM Staff R, Staffing, stated the NA assigned to work with Staff K was out ill both Saturday 08/10/2024 and Sunday 08/11/2024 and that staff should have marked on the staffing sheets if a bath aide or shower aide had been pulled to work on the floor. Staff R stated the facility had a specific phone that staff were to call when they called off ill and the person the phone was assigned to should attempt to fill the position. Staff R stated they had just taken over handling staffing and were unable to provide additional detail about coverage for the previous weekend.</p> <p>In an interview on 08/19/2024 at 2:32 PM Staff H, LPN, stated they worked on the weekends and the facility never had enough staff and residents had a lot of complaints about their wait times for care. Staff H stated they worked on 08/10/2024 and 08/11/2024 with Staff K and confirmed there was only one NA assigned to the hall. Staff H stated they tried to help but they were also covering a portion of another hall due to a nurse call off.</p> <p><Resident 8></p> <p>Review of the care plan dated 08/09/2024 showed staff were to provide supervision and verbal cues to Resident 8 while eating. Additionally, the staff were to provide total assistance of two staff for bathing twice weekly.</p> <p>Review of Resident 8's August and September 2024 bathing records showed they were not receiving showers at least twice weekly.</p> <p>In an interview on 08/08/2024 at 11:04 AM Collateral Contact (CC) 1 stated Resident 8 was not receiving the assistance they needed with eating and with their hygiene.</p> <p>In an interview on 08/16/2024 at 12:31 PM CC2 stated they or another visitor tried to stay with Resident 8 as often as possible as the resident had been falling when unattended. CC 2 stated they had concerns about the timeliness of staff response to resident needs and there were not enough staff to monitor the residents.</p> <p>Observation at 1:04 PM the same day showed Staff J and K, NAs, assisted Resident 8 to transfer from their wheelchair to their bed with a mechanical sit-to-stand lift, changed the resident's soiled clothes, and transferred them back to their wheelchair. Resident 8 was unsteady and required both staff to be present during the transfer and the care. At 1:22 PM Staff J was asked who was assisting other residents while both NAs were in the resident's room. Staff J stated it was just them and Staff G, LPN, and they had many residents who required at least two staff for assistance. At 1:24 PM (20 minutes) Staff J and K exited Resident 8's room.</p> <p>Further observations from 1:24 PM to 2:09 PM showed Resident 8 did not receive staff supervision or cueing during their meal, after staff dropped off their lunch tray.</p> <p>In an interview on 09/09/2024 at 2:57 PM, Staff S, LPN, stated Resident 8 required frequent checks and close monitoring for safety as well as extensive assistance of two staff with their care. Staff S stated even when two NAs were scheduled on the 100 hall it felt like there was not enough staff to monitor residents closely as there were many residents who required heavy care. Staff S stated they did not feel like staff were always able to provide timely care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Resident 3></p> <p>Review of the July 2024 progress notes showed Resident 3 was cognitively intact.</p> <p>In an interview on 08/09/2024 at 3:37 PM Resident 3 stated they did not feel safe at the facility due to lack of staff response to their call light. The resident stated it took longer than an hour for staff to respond to the call light and they had called the facility with their phone to reach staff at the nurse's station to request assistance.</p> <p><Resident 4></p> <p>Review of the July 2024 progress notes showed Resident 4 was cognitively intact.</p> <p>In an interview on 08/09/2024 at 4:06 PM CC4 stated staff did not respond timely to Resident 4's requests. CC4 stated the resident called them for assistance when facility staff did not respond so CC4 called the facility on the telephone to request assistance but it still took a long time for staff to respond.</p> <p>In an interview at 4:13 PM the same day, Resident 4 stated staff did not respond timely and they had to walk out from their room to the nurse cart to get staff assistance. Resident 4 stated they waited approximately two hours.</p> <p><Resident 5></p> <p>Review of the 08/22/2024 admission assessment showed Resident 5 was cognitively intact and was dependent on staff for assistance with activities of daily living.</p> <p>Review of the August and September 2024 bathing records on 09/04/2024 showed no showers and/or bed baths documented for Resident 5 (interval of 19 days since admission).</p> <p>In an interview on 09/03/2024 at 1:46 PM, Staff H, LPN, confirmed Resident 5 did not receive bathing assistance at the frequency they required and attributed it to a lack of staffing.</p> <p>In an interview on 09/04/2024 at 10:54 AM Resident 5 stated they did not get the assistance they required with bathing and staff did not always respond timely to the call light and/or requests for assistance with ADLs.</p> <p>In an interview on 09/04/2024 at 4:19 PM Staff B, Director of Nursing, stated when shower aides were not available NAs assigned to the halls were responsible for showers. Staff B stated the facility recently added more shower aides but the NA assigned to the 100 hall was on vacation.</p> <p><Resident 12></p> <p>Review of the 06/05/2024 admission assessment showed Resident 12 had mobility impairments to one arm and required staff assistance for meal set-up.</p> <p>Review of the care plan dated 06/01/2024 showed Resident 12 required supervision and cues during meals.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Continuous observation on 08/16/2024 from 1:24 PM to 2:09 PM showed Resident 12 did not receive staff supervision or cueing during their meal, after staff dropped off their lunch tray. The resident was observed to eat less than 25% of their meal.</p> <p>In an interview at 3:18 PM the same day Resident 12 stated their meat was too tough that day and they required assistance with their meal but no one was around to ask. The resident stated some days there were not enough staff and they did not always receive timely assistance.</p> <p>In an interview on 08/16/2024 at 3:50 PM Staff C, Resident Care Manager (RCM), stated the facility needed more staff as there were multiple residents on the 100 hall who required extensive assistance of two staff for transfer, bed mobility and toileting. Per Staff C, the facility admitted residents with complex medical needs who required close supervision and monitoring.</p> <p>See F-677 ADL Care for Dependent Residents for more information.</p> <p>Reference: (WAC) 388-97-1080 (1), 1090 (1)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure significant medications were given as ordered for 3 of 3 sampled residents (Resident 3, 4, 5), reviewed for medication administration. This failure placed the residents at risk for worsening of their medical conditions and unintended consequences.</p> <p>Findings included .</p> <p><Resident 3></p> <p>Per the 07/27/2024 hospital transition of care orders Resident 3 had the following medication orders: -an oral antibiotic, cephalexin 500 mg (milligrams), four times daily for seven days for a skin infection to their left lower leg-requip (medication to treat restless legs and neurological disorders) 3mg at bedtime-amitriptyline (tricyclic antidepressant) 25mg at bedtime</p> <p>-gabapentin 300mg three times daily (drug that affects chemicals and nerves involved in seizures and pain)</p> <p>Review of Resident 3's July 2024 Medication Administration Record (MAR) showed no administration of any medications.</p> <p>Review of the July 2024 progress notes showed Resident 3 admitted to the facility on [DATE] and transferred back to the hospital later the same day. Per the notes the orders for medications were most likely not sent to the pharmacy in time to allow for receipt from the automated medication dispensing system.</p> <p>In an interview on 08/09/2024 at 3:37 PM Resident 3 stated they admitted to the facility on a Saturday and were told that none of their medications would not be available from the pharmacy until the following Monday. The resident stated they kept asking about their medications and staff kept putting them off.</p> <p>In an interview on 09/04/2024 at 10:15 AM Staff D, Resident Care Manager (RCM), stated the manager assigned on-call for the weekend was responsible for admission paperwork, including entering medication orders, but the orders could not be activated until the resident walked in the front door. Staff D stated on a weekday medication orders had to be submitted to the pharmacy by 5:00 PM for timely processing, but they were not sure what times medications had to be submitted on a weekend. Staff D stated Resident 3 arrived late in the day on 07/27/2024 and was primarily concerned with pain control, which they were working on with the pharmacy.</p> <p><Resident 4></p> <p>Per the 07/05/2024 skilled nursing facility transfer orders Resident 4 had the following medications ordered: -an oral antibiotic twice daily for 14 days for a peritoneal abscess (pocket of pus and infected fluid in the belly)-regular insulin every six hours for diabetes (metabolic disorder that affects how the body uses sugar)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the July 2024 MAR showed no administration of any medications to Resident 4.</p> <p>Review of the July 2024 progress notes showed Resident 4 admitted to the facility on [DATE] and transferred back to the hospital later the same day. No notes related to the resident's medications other than pain medications were documented.</p> <p>In an interview on 08/09/2024 at 4:06 PM Collateral Contact (CC) 4 stated Resident 4 did not receive any of their scheduled medications the day they admitted to the facility. Per CC4, Staff H, Licensed Practical Nurse, reported to them that the facility did not receive records from the hospital, related to Resident 4's medications.</p> <p>In an interview on 08/19/2024 at 2:32 PM Staff H stated they were waiting for the pharmacy to deliver Resident 4's medications on 07/07/2024. Staff H stated the pharmacy was slow to deliver medications for many residents who were newly admitted , and it was unacceptable for Resident 4 because they were dependent on their insulin.</p> <p>In an interview on 09/04/2024 at 10:15 AM Staff D, Resident Care Manager, stated when a resident admitted to the facility a nurse manager was responsible to enter medication orders onto the MAR and the pharmacy would send routine medications, but the medications typically didn't arrive until the next day. Staff D stated the facility had an automated medication dispensing system that had common medications that were important for nurses to access for residents while waiting for the medications to arrive from the pharmacy.</p> <p>In an interview on 09/04/2024 at 11:20 AM Staff B stated the pharmacy was supposed to deliver important medications that were not available in the automated medication dispensing system within four hours. Staff B stated all of Resident 4's medications had been ordered and should have been available from the automated medication dispensing system, but Staff H did not yet have access to the system on 07/07/2024.</p> <p><Resident 5></p> <p>Per the 08/16/2024 hospital transition of care orders Resident 5 had the following medication orders:</p> <ul style="list-style-type: none"> -an intravenous (IV) antibiotic, ceftriaxone 2g (grams) every 24 hours for four days -an oral antibiotic, flagyl 500mg three times a day for four days -an IV antibiotic, vancomycin 1000mg every 24 hours for 37 days -losartan 25mg once daily for blood pressure-levothyroxine 50mcg (micrograms) every morning before breakfast <p>Review of Resident 5's August 2024 MAR showed no medications were administered on 08/16/2024 and only insulin was administered on 08/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the August 2024 progress notes showed Resident 5 admitted to the facility in the early afternoon on 08/16/2024. There was no documentation regarding the lack of administration of the resident's medications and/or notification to the medical provider of the missed/late doses.</p> <p>In an interview on 08/19/2024 at 2:32 PM, Staff H, Licensed Practical Nurse, stated Resident 5 was one of two residents who admitted on Friday 08/16/2024 and did not receive their medications until Saturday night or Sunday morning due to a delay in medication delivery. Staff H stated they did not know when the medications were delivered and required assistance from Staff C, Resident Care Manager, to locate the residents' medications once delivered.</p> <p>On 09/04/2024 at 10:54 AM Resident 5 was observed on an airbed in their room. The resident stated they did not receive their medications until the third day of their stay in the facility and were continuing to receive IV antibiotics for their severely infected wounds.</p> <p>Reference: WAC 388-97-1060(3)(k)(iii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Sullivan Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 East Fourth Spokane, WA 99216	
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)		
<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to provide meals with assistive devices in the correct position for use for 1 of 3 sampled residents (Resident 8), reviewed for meal service. This failure placed the resident at risk for decreased meal intake, loss of dignity, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the 08/13/20204 admission assessment showed Resident 8 had an impairment in mobility to their upper extremity and were dependent upon staff for eating assistance.</p> <p>Review of Resident 8's care plan for nutrition and activities of daily living (ADLs), initiated 08/06/2024, showed a goal of no further avoidable decline in ADLs and an intervention of staff to provide supervision and cues when the resident ate. There was no instruction to staff on how to maintain/encourage independence with eating for Resident 8 and/or assistive devices the resident utilized with their meals.</p> <p>In an interview on 08/08/2024 at 11:04 AM Collateral Contact (CC) 1 stated Resident 8 was not receiving adequate assistance with eating and was not provided with assistive devices they required.</p> <p>Observation on 08/16/2024, from 1:33 PM to 1:57 PM, showed Resident 8 and several other residents were seated at a table near the nurse station on the unit they resided on. Staff G, Licensed Practical Nurse, set a plate of food at the table in front of Resident 8, then left to pass out trays to other residents. A plate guard (a dining aid to promote independence and decrease spills for people who have difficulty keeping food on the plate) was applied to the edge of the plate furthest away from the resident. Resident 8 attempted to scoop food on their spoon themselves, and several times throughout the meal the resident's food was pushed off the plate onto their lap instead of onto their utensils. No staff members stayed to monitor Resident 8 and other residents eating their meal.</p> <p>In an interview during the meal observation, at 1:49 PM, Staff C, Resident Care Manager stated staff would know resident specific dietary information from the printed care plan in a book at the nurse's station. When asked about the use of the plate guard Staff C stated it was not in the correct position for use and turned Resident 8's plate until the plate guard was on to the side closest to the resident (to prevent food from accidentally scooping off the plate) and acknowledged that the care plan did not include direction to staff on how the plate guard was to be used.</p> <p>On 09/09/2024 at 1:17 PM a similar observation was made of Resident 8 attempting to feed themselves with a plate guard incorrectly applied (away from the resident) while food was pushed off the plate instead of onto the resident's utensils.</p> <p>Reference: (WAC) 388-97-1140 (2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505383	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Sullivan Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 East Fourth Spokane, WA 99216	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to ensure a system was in place in which residents' records were complete and accurate for 1 of 11 sampled residents (Resident 4) reviewed for accurate and complete medical records. The facility failed to ensure the medical record included medications administered for pain control immediately prior to a transfer to a hospital for pain control. Failure to maintain complete and accurate medical records placed the resident at risk for medical complications, unmet care needs, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of Resident 4's Medication Administration Record (MAR) for July 2024 showed no medications were administered to the resident on 07/07/2024. An order for oxycodone 5 mg (milligrams) one to two tablets every four hours as needed for pain was present on the MAR, but not administrations were documented. There was no order for acetaminophen on the MAR.</p> <p>Review of the July 2024 progress notes showed a note which documented Staff I, Registered Nurse, administered a pill in a cup to Resident 4 on 07/07/2024 at an unknown time. Per the notes, Staff I stated the medication was oxycodone 10 mg. The progress notes showed Resident 4 discharged to the hospital the same evening.</p> <p>In an interview on 08/09/2024 at 4:06 PM Collateral Contact (CC) 4 stated Resident 4 had issues with pain control and wound care on 07/07/2024, which resulted in a transfer to the hospital. Per CC4, Staff I stated they got permission from [the] supervisor to get one pain medication from the kiosk and was observed administering medication to Resident 4 approximately 10 minutes prior to the resident's transfer the hospital.</p> <p>In an interview on 08/13/2024 at 2:32 PM Staff H, Licensed Practical Nurse, stated they were the nurse responsible for Resident 4 on 07/07/2024. Staff H stated Staff I administered oxycodone at an unknown dose to Resident 4 prior to their transfer to the hospital and refused to enter documentation into the resident's record.</p> <p>In an interview on 09/04/2024 at 11:32 AM Staff I confirmed Staff H was the nurse responsible for Resident 4's care on 07/07/2024. Staff I denied administering any medications (documented or otherwise) to Resident 4.</p> <p>In an interview on 09/09/2024 at 10:55 AM Staff B, Director of Nursing, stated during an investigation of an allegation of misappropriation Staff I stated they administered acetaminophen to Resident 4 on 07/07/2024.</p> <p>See F-609 Reporting Alleged Violations and F-697 Pain Management for additional information.</p> <p>Reference: (WAC) 388-97-1720 (1)(a)(i)(ii), (2)(f)(m)</p>		

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NAME OF PROVIDER OR SUPPLIER Sullivan Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 East Fourth Spokane, WA 99216	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>38527</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one randomly observed staff (Staff L) wore personal protective equipment (PPE) in accordance with Centers for Disease Control (CDC) guidelines for prevention of spread of COVID-19 (a disease with a wide range of symptoms ranging from mild symptoms to severe illness caused by the SARS-CoV-2 virus). This failure placed residents (facility census 108) and staff at risk for spread of a contagious disease.</p> <p>Findings included .</p> <p>Review of the CDC guidelines titled, Infection Control Guidance: SARS-CoV-2, updated 06/24/2024, showed staff working on a unit or area of a facility experiencing a SARS-CoV-2 outbreak should use source control (face mask or respirator to cover a person's mouth and nose to prevent spread of respiratory secretions). Additionally, staff who entered the room of a resident with suspected or confirmed SARS-CoV-2 infection should use a N95 respirator (instead of source control), gown, gloves and eye protection.</p> <p>Review of a document titled, COVID, dated 08/08/2024, provided by Staff F, Infection Preventionist, showed nine residents residing on the 300 and 100 halls had tested positive for COVID-19 between 08/08/2024 and 08/12/2024. Resident 14 was included in the list of residents positive for COVID-19.</p> <p>In an interview on 08/15/2024 at 1:17 PM Collateral Contact (CC) 1 stated the facility was experiencing a COVID-19 outbreak, and staff members were not wearing PPE as required.</p> <p>Observation on 08/16/2024 at 1:38 PM showed Resident 14's room had a cart near the doorway with PPE available and a sign near the doorway instructing staff in procedures to apply and remove PPE when entering/leaving the room. Staff L, Nursing Assistant, was wearing a face mask to pass out meal trays on the 100 hall. Staff L entered Resident 14's room without applying the required PPE (N95, gown, gloves, and eye protection), then left the room without removing their face mask and applying clean source control.</p> <p>In an interview at 3:10PM the same day, Staff C, Resident Care Manager, confirmed Resident 14 was positive for COVID-19 and staff were expected to apply and remove PPE when entering COVID-19 positive room, even if it was just to drop off a tray. Staff C called Staff F on the telephone to confirm that Staff L should have changed their PPE when entering/leaving Resident 14's room.</p> <p>Reference: (WAC) 388-97-1320 (2)(b)</p>		