

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 10/08/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to ensure 1 of 6 sampled residents (Resident 8) and their representatives and medical provider, reviewed for notification of changes, received timely notification of an incident. This failure placed the resident at risk of delayed access to care, inability to participate in care planning, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of a 09/19/2024 facility investigation report showed Resident 8 was found in Resident 1's bed at 9:40 PM the previous evening. Per the report, Resident 8 was fully dressed but Resident 1 was undressed and both residents had diagnoses of dementia (group of symptoms affecting memory, thinking, and social abilities). Resident 8 was interviewed in their primary language the next morning and reported that Resident 1 brought them into Resident 1's room, encouraged them into bed, attempted to remove their clothes, and laid down next to them in bed. The report showed Resident 8's representatives and the medical provider were notified of the incident but did not include the date and time of the notifications.</p> <p>In an interview on 10/01/2024 at 2:36 PM a representative for Resident 8 stated they were not notified of the incident until the morning afterwards, approximately 13 hours later. The representative stated the resident, their representative(s), and the medical provider decided to transfer Resident 8 to the hospital for a medical exam to rule out sexual assault, but by the time they received notification of the incident, the resident had already received cares which limited the outcome of the medical exam.</p> <p>In an interview at 3:16 PM the same day, Staff B, Assistant Director of Nursing, stated they made the required notifications related to the incident between Resident 1 and Resident 8 the following day. Staff B stated the nurse who was responsible for the residents at the time of the incident should have notified the resident's representative, the medical provider, and local law enforcement immediately.</p> <p>See F-610 for additional information.</p> <p>Reference: (WAC) 388-97-0320 (1)(b)(d)</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident-to-resident abuse, for 1 of 6 sampled residents (Resident 8), reviewed for abuse. The failure to provide timely follow-up medical care and to preserve potential evidence placed the resident at risk of unidentified abuse.</p> <p>Findings included .</p> <p>Review of a 09/19/2024 facility investigation report showed Resident 8 was found in Resident 1's bed at 9:40 PM the previous evening. Per the report, Resident 8 was fully dressed but Resident 1 was undressed and both residents had diagnoses of dementia (group of symptoms affecting memory, thinking, and social abilities). Resident 1 was unable to give a statement about the incident due to their cognitive deficits. Resident 8 was not interviewed until the following morning. Resident 8 was interviewed in their primary language and denied sexual assault but was transferred to the hospital for additional examination due to the potential for sexual assault.</p> <p>In an interview on 10/01/2024 at 2:36 PM a representative for Resident 8 stated the resident had dementia and refused to talk to them about the incident. The representative stated the resident was not sent to the hospital until more than 13 hours after the incident, and the resident had been showered by facility staff and their clothing removed, prior to the hospital examination. They stated the resident's clothing had not yet been returned and should have been sent with the resident, unshowered, for evaluation to determine if semen or other fluids were present.</p> <p>Review of both the 09/19/2024 hospital records and the September 2024 facility bathing records showed Resident 8 received a shower prior to their hospital transfer and medical examination that day.</p> <p>In an interview on 10/01/2024 at 3:16 PM, Staff B, Assistant Director of Nursing, stated a medical exam was recommended by Resident 8's medical provider due to the potential for sexual assault and confirmed that the resident should have been transferred to the hospital in their same clothing and without a prior shower unless the resident requested.</p> <p>In a follow-up interview on 10/07/2024 at 11:20 AM Staff B stated they interviewed the staff working with Resident 8 on 09/19/2024 and confirmed the resident received a shower (and was changed into clean clothing) prior to their hospital transfer that day as it was their regularly scheduled shower day. Staff B stated the incident was not properly communicated amongst facility staff, and the shower aide was not aware of the need to potentially preserve evidence.</p> <p>See F-580 for additional information.</p> <p>Reference: (WAC) 388-97-0640 (6)(a)(b)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>38527</p> <p>Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident, their representative, and the State Long-Term Care Ombudsman for 1 of 5 sampled residents (Resident 10), reviewed for discharge. This failure placed the resident at risk of not having the opportunity to make informed decisions about transfers/discharges.</p> <p>Findings included .</p> <p>Review of the facility's policy titled, Notice of Transfer or Discharge, adopted on 08/01/2024, showed the facility would notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in a written notice using the Resident Notice of Transfer or Discharge. In the case of an emergency transfer, the written notice would be issued as soon as practical. Additionally, the facility would send a copy of the notice to the State Long-Term Care Ombudsman.</p> <p>Review of the 09/12/2024 admission assessment showed Resident 10 had cognitive impairments and physical behaviors that impacted their care one-to-three-days of the assessment period.</p> <p>Review of a 09/16/2024 facility investigation report showed at 7:30 AM that day Resident 10 was involved in a physical altercation with another resident and was transferred to the hospital for psychiatric evaluation.</p> <p>Review of Resident 10's electronic health record (under assessments, nursing progress notes, and documents) did not show documentation that a written notice of transfer/discharge was provided to Resident 10 and their representative.</p> <p>In an interview on 10/07/2024 at 3:31 PM a representative for Resident 10 stated on 09/16/2024 they were on their way to the facility to visit the resident when they received a notification that the resident had been discharged to the hospital. The representative stated the resident was still at the hospital and they had not received written notice of the transfer/discharge and/or any information regarding the resident's rights to appeal.</p> <p>In an interview on 10/08/2024 at 11:20 AM, Staff C, Social Services, stated that Resident 10's representative was verbally notified on 09/13/2024 that a hospital transfer may be required if the resident continued to have behaviors that put themselves and other residents at risk, but a formal discharge notice had not been issued during the resident's stay. Staff C stated they typically were the person to notify the Ombudsman of resident transfers and discharges via a telephone call, but they were not aware of any forms required, and did not believe the Ombudsman had been notified of Resident 10s transfer/discharge.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/08/2024 at 4:23 PM Staff B, Assistant Director of Nursing, stated they verbally notified Resident 10's representative and the resident's medical provider of the plan to transfer the resident to the hospital, but they were not aware of any requirements for written notices to be provided. Staff A, Administrator, stated if a discharge was for safety reasons the 30-day notice of intent to discharge was exempted.</p> <p>Reference: (WAC) 388-97-0120 (2)(a-d); -0140 (1)(a)(b)(c)(i-iii)</p>		