

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  01/16/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45433</p> <p>Based on interview, and record review the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 3 sampled residents (Resident 1) reviewed for medication management. The failure to ensure medications were acquired and administered as ordered placed residents at risk for adverse events related to missed medications.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of the 11/15/2024 care plan showed Resident 1 had a diagnosis of schizoaffective disorder, bipolar type ((a mental disorder characterized by symptoms of both schizophrenia (hallucinations, delusions, disorganized thinking) and a mood disorder (bouts of mania and depression))).</p> <p>In a telephone interview on 01/08/2025 at 11:09 AM with Staff C, Physican Assistant, they stated that they were the provider in the facility who worked with residents who used medications for psychological diagnoses requiring medication management. They further stated that they had worked with Resident 1 since shortly after they admitted . Staff C stated that they had been notified by the facility that Resident 1 had missed their medication to treat their schizoaffective disorder (clozapine) on 11/11/2024 and 11/12/2024. They further stated that they disscussed with the facility medical provider that the specific medication the resident was taking required close monitoring but typically stays in a person's system for about 2 days, and could be restarted at the same level within 48 hours of their last dose. They explained that their understanding was that the resident recieved the medication when it arrived from the pharmacy on 11/13/2024, but that they were showing some signs of increased irritability and distressing hallucinations at that time, as well as having kicked Staff A. They further explained that the Resident had gone to the hospital, at the request of family, on 11/15/2024, because the family felt Resident 1 was in a mental health crisis.</p> <p>Review of Resident 1's Medication Administration Record (MAR) for [DATE] showed an order for clozapine daily to be given at 7:00 PM. The MAR showed codes indicating the medication was not given on 11/11/2024 and 11/12/2024.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/08/2025 at 11:09 AM Staff D, Licensed Practical Nurse, stated that they had worked the previous Friday, 11/08/2024, with Resident 1, and had counted their supply of clozapine for the pharmacy on that day and there had been a six day supply. When they arrived back to work on 11/11/2024, a holiday, they could not find the clozapine for the 7:00 PM dose and reordered it from the pharmacy and notified the medical provider. The next day when they came to work the medication had still not arrived and the medical provider was again notified. Staff D explained that they understood that their order on 11/11/2024 had missed the cutoff time for ordering medication to arrive the next day and so was not delivered until 11:45 AM on 11/13/2024.</p> <p>Review of Resident 1's nursing progress notes showed that on 11/12/2024 at 11:21 AM Staff D wrote, [Resident 1] has seemed depressed today and yesterday. Today [they] ha[ve] been tearful and crying most of the day. Staying in [their] room more than usual. Short-tempered and snapping at staff sometimes. Has refused/declined some cares. Behavior concern report completed and turned in to social services.</p> <p>Review of Resident 1's nursing progress notes showed that on 11/12/2024 at 5:35 PM Staff D wrote, Notified provider of resident's increased behaviors today. Noted to have aggression, kicking the staff members, yelling and swearing at staff. Noted that [they] missed 1 dose of clozapine on 11/11/24 which could be the cause of increased behaviors. Provider notified of missed dose and [family] concerns [related to] increased agitation. Received a 1 time of order of 12.5mg of Seroquel for agitation. MAR updated.</p> <p>Review of Resident 1's nuring progress notes showed that on 11/13/2024 at 11:32 AM, [Resident 1] continues with strange behavior. No adversities noted from one time dose of seroquel. Has been tearful/crying at times, laughing at other times, and talking to [themselves] intermittently. No aggressive behavior toward staff or other resident's noted or reported this shift.</p> <p>Review of Resident 1's nuring progress notes showed that on 11/14/2024 at 11:33 AM, [Resident 1] continues with behaviors. Talking to [themselves] constantly, having conversations with [themselves], being very loud and verbally abusive at random times. Friendly at times, hostile at times. Appears to be very manic.</p> <p>Review of Resident 1's nuring progress notes showed that on 11/15/2024 at 1:16 PM, Resident 1's family member arrived to the facility and took them to a local hospital for evaluation at 11:15 AM, after Resident 1 refused to go with Emergency Medical Technicians, who had been called at the request of the family member.</p> <p>In a interview with Staff B, Director of Nursing, on 01/16/2025 at 12:05 PM they stated that they had investigated the medication error for Resident 1 that ocured in November of 2024. They stated that at that time the facility was using a pharmacy based in Vancouver, [NAME] and that they had been having difficulty getting medications they ordered the same day or the next day. In the instance with Resident 1, Staff D had not realized the medication was not available until just before 7:00 PM on 11/11/2024, when the medication was scheduled to be administered. This meant that the cutoff time for delivery the next day had been missed and the medication was not delivered until 11/13/2024 when the medication was given upon its arrival, per the medical provider order.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/16/2025 at 12:00 PM Staff A, Administrator, stated that the interdisciplinary team had recognized there was a problem with timely deliver of medication from the Vancouver based pharmacy prior to this incident. They produced e-mails showing corespondance with the pharmacy account manager starting on 10/25/2024 asking about how they could swith to the Spokane based Pharmacy. They further stated that they were in the process of switching during the medication incident with Resident 1 and had completed the switch to the local pharmacy on 12/01/2024. Staff A stated that this switch made it possible to get medication deliveries the same day.</p> <p>Review of hospital records for Resident 1, dated from 11/15/2024 through 01/07/2025, showed medical provider conclusion that off meds contributed but strongly suspect neurocognitve disorder (dementia) [related to] alcohol abuse is causing worsening Schizo disorder.</p> <p>Reference: (WAC) 388-97-1300 (1)(a)(b)(i)(ii)</p> <p>This citation is Past Noncompliance.</p>		