

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 06/25/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a clean, safe, and homelike environment for 2 of 3 residents (Residents 13 and 6) and 4 of 6 shower rooms (Halls 100, 200, 500, and 600), reviewed for environment. This failure placed the residents at risk for potential accidents and not feeling safe/secure with their living conditions. Findings included . Review of the facility's policy titled, Maintenance Service, dated 12/2009, showed the maintenance director was responsible for developing and maintaining a schedule of maintenance service to ensure that the building, grounds, and equipment are maintained in a safe and operable manner. The maintenance director was also responsible for maintaining the building in good repair and free of hazards. Resident 56 Resident 56 was admitted to the facility with diagnoses including necrotizing fasciitis (an aggressive tissue bacterial infection), asthma (a condition that causes airways to swell, narrow and fill with mucous), and obesity. The 06/03/2026 comprehensive assessment showed Resident 56 required the assistance of one staff member for bathing and had an intact cognition. Resident 103 Resident 103 was admitted to the facility to the facility on [DATE] with diagnoses including lung and brain cancer, malnutrition, and anxiety. The 05/19/2026 comprehensive assessment showed Resident 103 was independent for activities of daily living (ADLs) and an intact cognition. Resident 9 Resident 9 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), diabetes (excess sugar in the blood), and depression. The 06/18/2026 comprehensive assessment showed Resident 9 required the assistance of one staff member for showering and set-up of assistance for ADLs. The assessment also showed Resident 9 had a moderate impaired cognition. Shower rooms (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 06/21/2026 at 10:30 AM, showed the shower room on the 500 Hall had a strong odor of mildew present inside the shower stall area. The interior left wall of the shower stall showed severe water damage, including deep gouges (deep groove, scratch on a surface) measuring 12 inches (in-a unit of measure) by five in, which exposed the underlying drywall (type of board used to create walls) and metal structural framing. The opposite side of this left wall showed peeling paint and multiple areas of missing paint, exposing the underlying drywall. Additionally, the right wall of the shower stall showed water damage with bubbling paint measuring five in by two in, exposing the underlying drywall and metal. The ledge situated to the right of the shower area had an unsealed, loose metal top piece measuring two feet (ft- a unit of measure) that was pulled upward, creating sharp, jagged metal edges.~ An observation on 06/21/2026 at 10:42 AM, showed the shower room on the 600 Hall shower stall edges were sealed with four ft of duct tape applied to the vertical edges on both sides. The top right edge of the stall was missing a six in section of tile, exposing sharp edges. The handwashing sink was pulling away from the structural wall, with chipped and missing paint that exposed the underlying drywall. Behind the toilet fixture, two baseball-sized unpainted circular areas with exposed screw holes were present on both the right and left sides of the wall. Lying loose across the wall within physical reach was a sharp-edged metal corner piece with jagged edges pointed upward.~A black and brown substance was accumulated around the perimeter edges of the tile inside the shower stall. The front area of the shower stall exhibited a four in by two in section of cracked and missing tile, and the interior wall to the right of the entryway door showed multiple dime- to quarter- sized deep scratches that exposed the underlying drywall.~ During an interview on 06/21/2026 at 11:51 AM, Resident 56 stated the shower room on Hall 100, was moldy and had poor ventilation. Resident 56 stated they did not like to shower there and made it hard for them to breathe. An observation on 06/21/2026 at 1:49 PM, showed the 100 Hall shower room, had multiple broken floor tiles that were crushed and had blackish/brown debris in the grout lines within the shower stall area. The short wall that created the shower stall area had blackish/brown thick debris that connected the shower wall to the floor. On the right side of the shower area was a one ft by three ft area of brown/yellow film that covered the floor tiles. To the right of the shower stall area was a blue bin that overflowed with used white towels and a bag of dirty clothes. To the left of the shower stall area were 12 broken and crushed floor tiles with exposed concrete and blackish/brown debris in the grout lines. To the left of the shower area was a bedside table with white towels and a brown film on the exposed table area. There was a shower chair lying on its side, surrounded by a reddish/brown film on the floor. Along the back wall near the shower area and toilet was a five ft area of loose tile, with blackish/brown debris exposed and white caulking peeling from the wall. An observation on 06/21/2026 at 1:54 PM, showed the 200 Hall shower room had a four ft section of wall that was cracked and peeling paint. The floor in the shower stall area had a 10 in by eight in section of the linoleum peeled up and exposed concrete with stagnant water. The surrounding area of the peeling linoleum showed a six in by five in area of white/green cracked discoloration. The wall in the shower stall area had an eight inch by 10 in section in the center of the wall that had peeled paint that was white/green discolored and missing paint that exposed the underlayment and metal mesh. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower room perimeter had a white powdery substance along the mopboard and floor joint. In the right corner of the shower room was a mounted metal cabinet with a brown, rusty orange color on the cabinet. On top of the metal cabinet was a pile of white bath towels, blue pants and an open package of incontinence briefs. During an interview on 06/24/2026 at 10:29 AM, Staff J, Maintenance Director, stated the staff communicated any issues or repairs needed through the TELS (an electronic computer system used to create work orders). Staff J stated they were not notified through the electronic system, so they did not receive a work order for the issue. Staff J stated they frequently identified issues through their own observations because staff frequently failed to use the TELS system. Staff J stated they did not conduct walking rounds of the facility on a consistent schedule and only performed room checks for repairs needed twice a year. Staff J stated their daily walking rounds were just to check for any obstructions and critical issues. Staff J further stated they were aware that the shower rooms in the facility needed a lot of work. During an interview on 06/24/2026 at 10:50 AM, Staff T, Nursing Assistant, stated they bathed residents in the shower rooms. Staff T stated they were aware of the condition of the shower rooms and have entered repair requests into TELS as required. Staff T stated the walls had peeling paint and room would become very hot and residents complained. Staff T stated there was a metal piece on the right shower stall ledge that had a metal piece that was lifted and was a safety concern, as a resident may harm themselves on it. During an interview on 06/24/2026 at 10:57 AM, Resident 103 stated they did not take showers at the facility because the shower room in their hall, (500 Hall), was in bad condition. Resident 103 stated they left the facility to shower at a friend's home. Resident 103 stated the shower room had holes in the walls, peeling paint and crumbling areas of the walls. During an interview on 06/24/2026 at 11:03 AM, Resident 9 stated the shower room on Hall 500 was terrible. Resident 9 stated it was moldy, with green and brown areas on the walls that were falling apart. Resident 9 stated one side of the shower stall ledge had a metal piece on the top that was lifted and sharp. Resident 9 stated to bathe in that shower room made them feel disgusting. During an interview on 06/24/2026 at 10:39 AM, Staff A, Administrator, stated they expected maintenance rounds to be completed monthly. Staff A stated they were aware of the physical deficiencies in the shower rooms. Staff A further stated walking rounds have not been completed and acknowledged the shower rooms needed attention. Resident Rooms Resident room [ROOM NUMBER]-A Resident 13 was admitted to the facility with diagnoses including Alzheimer's (a progressive disease that destroys memory and other important mental functions), sepsis, and hospice care (a type of care that focuses on comfort and quality of life for an individual who was terminally ill or near the end of their life). The 05/21/2026 comprehensive assessment showed Resident 13 was dependent on one to (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	two staff members for ADLs and had a severe impaired cognition. An observation on 06/22/2026 at 10:23 AM, showed Resident 13's room had an exterior electrical outlet that was located near the floor on the wall. The area above the outlet had missing paint and exposed drywall and deep gouges. The electrical wire covering was not mounted on the wall evenly and showed unpainted areas, exposed drywall, white patches and scrapes. Resident room [ROOM NUMBER]-A Resident 6 was admitted to the facility with diagnoses including multiple sclerosis (a disease that damages communication between the brain and body, leading to muscle weakness, vision changes and memory issues), emphysema (a lung condition that makes it hard to breathe), and sepsis (a life-threatening body infection). The 06/06/2026 comprehensive assessment showed Resident 5 required the assistance of one staff member for ADLs and had an intact cognition. During a concurrent observation and interview on 06/23/2026 at 2:53 PM, showed Resident 6's bathroom had two holes in the wall across from the toilet that was covered with blue tape that was peeling. The wall next to the toilet had two areas behind the grab bar, three inches by three-inch round areas that were unpainted. The bathroom base trim was peeling from the wall on the left side of the room. The bathroom wood door had multiple long scratches across the front and back of the door that discolored the wood. The wall next to Resident 6's bed had deep gouges and scrapes four feet up their wall by their bed. Resident 6 stated the room looked like s**t, and their bathroom and room should be in a better condition. During an interview on 06/25/2026 at 8:52 AM, Staff A, Administrator, stated they would need to speak to maintenance and have these identified areas repaired. Reference: WAC 388-97-0880(1)(2)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to provide food at proper temperatures and palatable taste for 5 of 8 residents (Resident 4, 97, 92, 56 and 48) reviewed for food. This failure placed residents at risk for foodborne illness, decreased nutritional intake and weight loss. Findings included. Review of a policy titled, Food Safety, dated 02/2019, showed cold products will reach temperatures no greater than 41 degrees Fahrenheit (F-unit of measure). Review of a facility undated document titled Schedule of Mealtimes, showed Breakfast was served between 7:00 AM to 8:00AM, Lunch was served from 12:00 PM to 1:00PM and Dinner was served from 5:00 PM to 6:00 PM. Resident 4 During an interview on 06/22/2026 at 9:32 AM, Resident 4 stated the warm food they received was cold and the cold food was warm. Resident 97 During an interview on 06/21/2026 at 2:51 PM, Resident 97 stated the drinks they were provided were warm and not cold, and the ice cream was melted by the time they received their meals. During an observation on 06/23/2026 at 1:14 PM, Staff M, Dietary Manager, served a test tray to the surveyors and was checked for temperatures by Staff M, with the following results: Milk 48.9 F degrees Orange Juice 57.9 F degrees Strawberry Yogurt 44.2 F degrees Normal Range for cold food and drink is at or below 41 F degrees During a second test tray observation and concurrent interview on 06/24/2026 at 1:22 PM, Staff M served the test tray to the surveyors and checked the temperatures with the following results: Milk 52 F degrees (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Apple Juice 51.3 F degrees Peach Yogurt 60.4 F degrees Staff M stated the temperatures of the food and drink items were not within the required parameters for service and confirmed the cold food and drinks should be held at 41 F degrees or lower. Resident 92 During an interview on 06/21/2026 at 10:43 AM, Resident 92 stated they did not receive their breakfast until 9:45 AM that morning. Resident 92 stated their breakfast was cold and not hot or even warm. Resident 92 stated the food was lousy. Resident 92 stated the meat was very dry and difficult to eat. Resident 92 stated there was no organized system for food trays to be distributed timely. Resident 92 stated the staff would search through the food cart to get a resident's tray and then deliver to where there were, either the dining table or their rooms. An observation on 06/21/2026 at 12:50 PM showed the Hall 100 food cart delivered for lunch. During the lunch tray deliveries, the food cart door was left open for 14 minutes. During a follow-up interview on 06/25/2026 at 10:11 AM, Resident 92 stated their dinner the previous night was orange chicken that they could not cut it up as it was too tough, vegetables were mushy and the rice was terrible. Resident 92 stated they did not receive this morning's breakfast for 15 minutes after it was delivered to their area and their food was cold. Resident 56 During an interview on 06/21/2026 at 11:51 AM, Resident 56 stated the food was served cold when it should have been hot. Resident 56 stated the meat they would be served was very thin and overcooked and they did not like it. Resident 56 stated the meals were repetitive and lacked taste. Resident 48 During an interview on 06/21/2026 at 12:30 PM, Resident 48 stated the food tasted terrible. Resident 48 stated the food was cold, when it should be hot, and overcooked. Resident 48 stated the tuna fish and egg salad were horrible, and the tomato soup tasted like lukewarm tomato juice. An observation on 06/24/2026 at 1:03 PM showed the Hall 200 food cart delivered for lunch. During the lunch tray deliveries, the food cart door was left open for 13 minutes. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 06/25/2026 at 9:01 AM, Resident 48 stated the food was still lukewarm, never hot and tasted bad. Resident 48 stated their dinner the previous evening was mushy vegetables, chicken had soggy breading and tasted frozen. Resident 48 stated they could not tolerate the meal, and it was icky. Resident 48 stated they were aware of other options, however that would include tuna fish and egg salad which was horrible and not fresh tasting. Reference WAC: 388-97-1100(1)(2)(3)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1) ensure dry goods and refrigerated foods were properly stored, covered, and labeled with use-by dates for food safety tracking, and 2) maintain the kitchen, dishwashing area, entrance, and rear exit environments in a clean, sanitary, and repaired condition to prevent cross-contamination (harmful spread of diseases) for 1 of 1 kitchen reviewed. These failures placed residents at an increased risk for foodborne illnesses. Findings included. Review of the Washington State Retail Food Code [PHONE NUMBER]6(1)(2)(a)(b)(3)(4), dated March 1, 2022, showed ready-to-eat or refrigerated, time/temperature control for food safety must be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four hours, to indicate the date or day by which the food must be consumed on the premises. Prepared foods must have the date or day of preparation, with a date to discard the food on or before the last date or day the food can be consumed on the premises. Review of the Washington State Retail Food Code [PHONE NUMBER]1(1)(a)(b)(c)(2)(3), dated March 1, 2022, showed food must be protected from contamination by storing the food in a clean, dry location at least six inches above the floor. Review of the Washington State Retail Food Code [PHONE NUMBER]0 and [PHONE NUMBER]0(3), dated March 1, 2022, showed physical plant structures and equipment must be maintained in good repair and kept clean and free of an accumulation of dust, dirt, food debris, grease, and grime. Review of facility's policy titled, Food Storage, dated 07/25/2024 showed foods shall be received and stored in a manner that complies with safe food handling practices. Staff were to label and date all foods when they were opened and the date when the food items must be used by. During the initial kitchen observation on 06/21/2026 at 8:36 AM showed the following: Dry storage: one case of milk used to prop open a door, one box containing five containers of salt, one container of Glucerna (brand of nutritional supplement drink), and one Ensure (brand of nutritional supplement drink) stored on the floor. Additionally, there were two cases of frozen chicken breasts stored on the freezer floor. Uncovered food: a cooling rack that held three trays of cookies, one tray of chocolate brownies, and five pieces of pecan pie were completely uncovered in a high-traffic area where staff traveled in and out of the kitchen. Food labeling: Multiple prepared foods and bulk storage items without appropriate or clear dates; Cookie bin: 22 bags of chocolate chip cookies with no dates, Refrigerator number one: 18 glasses of apple juice, 27 glasses of cranberry juice, 28 glasses of orange juice, 36 glasses of milk and seven glasses of thickened juice all without dates. Walk-in refrigerator showed a single date for: salad mix 06/06, tuna 06/15, applesauce 06/16, chocolate pudding 06/17, pan of white cake 06/17, egg salad 06/20 and two opened bags of lettuce. Kitchen bulk bins showed a single date for: flour 06/01 rice 06/02, and sugar 06/05. Dry storage bins showed a single date for: breadcrumbs 04/10, oats 06/02, brown sugar 06/16. During an interview on 06/21/2026 at 8:50 AM, Staff V, Cook, stated they thought the markings on the food items were made dates. Staff V stated there were no use by dates and they were unsure what the dates meant. During an interview on 06/21/2026 at 9:20 AM, Staff M, Dietary Manager, stated the facility does not place use by dates on food bins or prepared food. During a concurrent observation and interview on 06/22/2026 at 11:42 AM, Staff W, Cook, stated the single dates on the flour, sugar, oats and rice bulk bins were the dates the items were originally placed into the bins. Staff W stated they did not know when the bulk items should be used by. Staff W stated they assumed the standard was maybe three months. Staff W stated the food items in the walk-in refrigerator had a prepared dated and no use by (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date. Staff W stated the kitchen standard was to never use an item after it had been stored for more than three days. However, direct observation showed multiple food items exceeded this threshold. Staff W showed a container of applesauce dated 06/15 (six days old) and a container of white cheese dated 06/06 (15 days old), and stated these items were not good and should be thrown out. Environment Dishwashing drain: showed the food trap and drain underneath the dishwasher was filled to the top with food and debris. Wall maintenance: showed the entire length of the wall located directly behind the dishwasher was heavily coated in accumulated black dirt, grease and grime. Floor cleanliness: showed the entire floor surface underneath the dishwasher covered in garbage, black grease and grime. Walk-in cooler: showed the wall located to the left of the walk-in cooler had damage on the lower portion of the walk-in door. The metal wall covering was pulling away from the wall. A two-foot section at the bottom was completely open and detached and exposed the underlying wall, studs, accumulated dirt and black grime. Dish room door: showed the door that led into the dish room had deep scratches, exposed bare wood, with visible grease and grime that dripped down the door front Kitchen Entrance and Rear Exit An observation on 06/22/2026 at 3:04 PM showed: Entrance door: to the right side of the door a 9 inch (in- a unit of measure) by 5 in. section of missing paint alongside eight exposed drill holes. A utility access cover to a piping system failed to close that left interior pipes completely exposed and revealed a heavy rust accumulation along the bottom of the covering. Multiple quarter and dime sized areas had chipped paint visible throughout the entrance. The carpeted hallway that led to the back door was littered with scattered garbage that included a pile of mixed garbage in the corner to the right of the kitchen door. The back door was heavily coated in grease and grime with prominent black streaks and drippings. There was a four in. section of metal weather stripping at the bottom right of the back door that was bent and broken. During a concurrent observation and interview on 06/24/2026 at 10:22 AM, Staff M stated the expectation was for each shift to clean the kitchen, with sweeping and mopping completed each night. Staff M observed the area underneath the dishwasher, kitchen hallway and dishwasher walls and stated that the area had not been cleaned, and they expected the cleaning to be done daily, and it had not been completed. During a combined observation and interview on 06/24/2026 at 10:39 AM, Staff J, Maintenance Director and Staff A, Administrator, reviewed the kitchen environment. Staff J stated the kitchen definitely need to have more attention. Staff A stated the kitchen needed work and agreed the area was not clean. Reference WAC: 388-97-1100(3), 388-97-2980(3)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP- precautions to protect residents from multidrug-resistant organisms [MDRO-a germs that are resistant to medications that treat infections]) were identified for 1 of 3 residents (Resident 148) reviewed for infection control. Additionally, the facility failed to ensure EBP, and hand hygiene were implemented for 2 of 2 residents (Resident 6 and 139) as required during urinary catheterizations (a flexible tube inserted through the urethra [a small duct that carries urine from the bladder] into the bladder to drain urine). This failure placed the residents at risk for the spread of infections, illnesses and unnecessary health consequences. Findings included. Review of Centers for Disease Control and Prevention (CDC) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 06/2024, showed EBP's were an infection control intervention to reduce transmission of MDROs in nursing homes. EBPs required personal protective equipment (PPE-gloves, gown and face protection when performing an activity with risk of splash or spray) used during high-contact resident care activities, that include dressing, bathing, transferring, hygiene care, linen changes, changing briefs or toilet assistance, device care (urinary catheters) and wound care, for residents known to be colonized or infected with an MDRO and residents at increased risk of obtaining an MDRO. Resident 148 Review of Resident 148's medical record showed they were admitted to the facility with diagnoses which included dementia (a decline in mental function), Parkinson's disease (a progressive disease that destroys nerve cells) and history of bladder cancer with a urostomy (an opening in the abdomen which allows urine to drain into a collection bag). The comprehensive assessment dated [DATE] showed Resident 148 had an impaired cognition and required substantial assistance from staff members for activities of daily living (ADLs), including dressing, grooming, bathing and elimination needs. Review of Resident 148's admission nurse form, dated 06/13/2025, showed while in the hospital the resident was treated for MDROs in their urine with intravenous antibiotics (antibiotics delivered directly into the blood stream by a small needle inserted into a vein). The source of the infection was identified in the resident's urinary tract and required EBP upon admission to the facility to mitigate the risk of spreading the infection. During multiple observations of Resident 148's room showed on 06/21/2026 at 9:53 AM, 06/22/2026 at 10:22 AM, and 06/23/2026 at 10:26 AM, there was no EBP signage posted outside the resident's room to identify the staff requirement to follow EBP. During an observation and concurrent interview on 06/23/2026 at 11:30 AM, showed Staff U, Nursing (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (NA) and Staff Z, NA, assist Resident 148 to the restroom. Staff Z obtained a urinal and emptied Resident 148's urinary catheter bag wearing gloves only. Staff U assisted Resident 148 to change their clothes and wore only gloves. Staff U and Staff Z stated Resident 148 did not have an EBP sign posted to identify if they required EBP and there was not a supply of gowns or other PPE placed near Resident 148's room. During an interview on 06/24/2026 at 11:23 AM, Staff B, Director of Nursing, stated their expectation was residents that admitted with catheters were to be placed on EBPs and Resident 148 had been missed. Staff B stated staff were expected to wear correct PPE, including gown and gloves before providing care to the residents. Resident 6 Resident 6 was admitted to the facility with diagnoses including multiple sclerosis (a disease that damages communication between the brain and body, leading to muscle weakness, vision changes and memory issues), neuromuscular dysfunction of the bladder (nerve damage that interferes with normal control for bladder storage and emptying), and sepsis (a life-threatening body infection). The 06/06/2026 comprehensive assessment showed Resident 5 required the assistance of one staff member for ADLs and had an intact cognition. Review of the medical record showed Resident 139 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (BPH-a noncancerous enlargement of the prostate gland) with urinary retention (unable to empty all the urine from the bladder), recurrent urinary tract infections (infection in any part of the urinary system), and a left below the knee amputation. Review of Resident 139's nursing admission note, dated 06/19/2026 at 3:04 PM, showed they were alert and oriented, required the assistance of one staff member for transfers and care. An observation on 06/23/2026 at 3:04 PM, showed Staff Q, Licensed Practical Nurse, entered Resident 6's room that had an EBP sign on their door to perform a urinary catheterization (a procedure that requires a flexible tube be inserted through the urethra into the bladder to drain urine) for Resident 6. Staff Q performed hand hygiene and donned (put on) clean gloves and did not don a gown. Staff Q placed a urinary catheterization kit on Resident 6's bedside table and proceeded to obtain a cleaning wipe and wipe down the bedside table, then removed their gloves and placed them into the trash. In the same observation, Staff Q donned another pair of gloves, without performing hand hygiene, obtained two urinals from the restroom, opened the urinary catheterization kit, removed two protective drapes and placed one on the resident's bed and the other around Resident 6's genitalia. Staff Q removed the cleansing swabs from the kit and swabbed Resident 6's genitalia, removed gloves then removed sterile gloves from the kit and donned, without performing hand hygiene. Staff Q proceeded to prepare the urinary catheter as required and with their left hand, held Resident 6's genitalia and with their right hand, inserted the urinary catheter into the urethra until urine returned and flowed into a urinal. Upon completion of the urinary catheterization, Staff Q removed the catheter and placed it into the trash, removed their gloves, obtained another clean pair of gloves from the box (continued on next page)		

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 06/25/2026
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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and donned, then dumped the urine form the urinal into the toilet, and then rinsed the urinal in the resident's sink. Staff Q then returned to the bedside and collected all the used items and placed them into the trash and removed gloves and used hand sanitizer. Resident 139 Review of the medical record showed Resident 139 was admitted to the facility on [DATE] with diagnoses including benign prostatic hyperplasia (BPH-a noncancerous enlargement of the prostate gland) with urinary retention (unable to empty all the urine from the bladder), recurrent urinary tract infections (infection in any part of the urinary system), and a left below the knee amputation. Review of Resident 139's nursing admission note, dated 06/19/2026 at 3:04 PM, showed they were alert and oriented, required the assistance of one staff member for transfers and care. An observation on 06/23/2026 at 3:36 PM, showed Staff Q entered Resident 139's room that was identified as EBP by a posted sign on their door, without a gown as required. Staff Q donned gloves and placed the urinary catheterization kit onto the resident's bedside table. Staff Q removed Resident 139's pants and briefs, opened the kit, removed a drape and placed next to the resident on their bed and a second around the resident's genitalia. Staff Q removed their gloves and donned sterile gloves from the kit without hand hygiene. Staff Q removed the catheter and placed onto the sterile glove package, opened the lubricant and cleanser swab and with their left hand held the Resident 139's genitalia and used their right hand to cleanse the genitalia with the swab. Staff Q removed their left hand from Resident 139 once they completed the cleansing and obtained another cleansing swab from the package and did a secondary cleansing and then disposed into the trash. Staff Q proceeded to obtain the catheter and apply lubricant then inserted into Resident 139's urethra and placed a urinal between the resident's legs to collect the urine. When urine began to flow into the urinal, Staff Q took their right hand and rested on their lower back with soiled gloves on, then after a moment placed the same hand back on the catheter. When urine stopped flowing, Staff Q withdrew the catheter and removed the drapes and placed them into the trash. Staff Q took the urinal to the toilet and poured out the urine, rinsed the used urinal in the resident's sink, removed their gloves and donned new gloves without hand hygiene. Staff Q returned to Resident 139's bedside to pull up their brief and pants and assist with bed positioning. Staff Q removed their gloves and donned new gloves without hand hygiene, obtained peri-care wipes from Resident 139's cupboard and cleansed Resident 139's peri-area, when Staff Q completed the care, continued to pull up the resident's brief and pants. Staff Q gathered the used urinary catheter kit supplies and removed their gloves, placed them into the trash and with their bare hands, tied up the trash bag, grabbed a box of gloves, placed the resident's cell phone, water cup and miscellaneous papers and glasses back onto the bedside table. During an interview on 06/23/2026 at 3:52 PM, Staff Q stated they tried to maintain sterility with both resident's urinary catheterizations. Staff Q stated they did change their gloves many times as they were trying not to cross-contaminate. Staff Q stated they were supposed to use hand sanitizer each time they changed gloves or were contaminated, but they did not. Staff Q stated they did not want to bring and leave a sanitizer into the residents' rooms and did not want to use the wall mounted hand sanitizer in their rooms, as they did not want to keep going back and forth during the urinary catheterizations. Staff Q stated they were supposed to wear a gown for both residents as they were (continued on next page)		

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Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on EBP. Staff Q stated EBP was to protect the residents from any contamination, and they did not follow the EBP requirements. During an interview on 06/24/2026 at 4:57 PM, Staff A, Administrator, stated all staff should be using PPE and sanitizing hands when necessary and required. Staff A stated Staff Q should have worn EBP protections during the urinary catheterizations. Reference WAC: 388-97-1320(1)(a)(c)(5)(b)		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure residents had access to their personal trust fund money outside of normal business hours (Monday through Friday, 8:00 AM to 5:00 PM) and during weekends for 2 of 6 residents (Resident 4 and 76) reviewed for personal funds. This failure placed residents at risk for unmet financial needs and limited their right to self-determination. Findings included. During an interview on 06/22/2026 at 9:34 AM, Resident 4 stated they could not access their personal money after 5:00 PM during the week or on the weekends. During an interview on 06/23/2026 at 2:15 PM, Resident 76 stated they did not have access to their personal money on the weekends or after administration left during the week, further stating I don't even try because I know I cannot get it. During an interview on 06/23/2026 at 1:41 PM, Staff O, Registered Nurse, stated if the business office were open when the resident requested money, they would have business office staff talk with the resident. Staff O stated they were unsure of the process for accessing personal trust funds after hours or on weekends. During an interview on 06/23/2026 at 1:45 PM, Staff K, Business Office Manager (BOM), stated they had access to the resident's trust accounts, and the activities department got a list during the week of everyone who wanted to go shopping or who wanted money. When asked about weekend and after-hours access to personal trust funds, Staff K stated the facility had a weekend supervisor, Staff N, Licensed Practical Nurse (LPN), who had access to the cash box in the BOM's office. Staff K stated Staff N was the only person who had access besides the BOM. Staff K further stated that they were not sure of the process when Staff N was not available. During an interview on 06/23/2026 at 2:00 PM, Staff A, Administrator, stated that the facility had a weekend supervisor, Staff N, who was in the building on weekends until 10:00 PM to distribute funds. Staff A stated that no one else could distribute funds after hours on the weekends or during the week. Staff A stated that when a resident needed money after hours or after Staff N left the facility for the day, any staff member could call the BOM at home, and they could come to the facility to retrieve the money. Staff A further stated that staff could also call them directly and they would come to the facility to retrieve the money. Reference WAC: 388-97-0340(1)(2)(3)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident was free from physical restraints and had an evaluation and documented medical symptoms to validate the use of restraints for 1 of 2 residents (Resident 148) reviewed for restraints. Additionally, the resident's record did not show the least restrictive alternatives had been attempted prior to the restraint use or documentation of ongoing monitoring. This failure placed the residents at risk for injury, agitation and a decline in physical function. Findings included. Review of a facility policy titled Physical Restraints and Enabler Devices revised 07/2023 showed the definition of a restraint is as follows; A) Is attached or adjacent to the resident's body, B) Cannot be removed by the resident, C) Restricts the residents' freedom of movement. Resident 148 Review of Resident 148's medical record showed they were admitted to the facility with diagnoses which included dementia (a decline in mental ability) and Parkinson's disease (a progressive disease that destroys nerve function). Review of the resident's comprehensive assessment dated [DATE] showed the resident had cognitive impairment and required substantial assistance from staff for daily activities including dressing, grooming, bathing and mobility. During an observation on 06/21/2026 from 9:52 AM to 11:10 AM, showed Resident 148 in their room lying in bed. There were three pillows in the bed and a pillow on the floor. One side of the resident's bed was against the wall, and the other side was open to the room. The side open to the room had the sheet pulled up and a pillow wedged under the sheet creating a barrier to the edge of the bed. The resident attempted to roll to their right side, however had limited bed mobility related to the pillow that had been placed under the sheet. During an observation on 06/23/2026 from 10:11 AM to 11:30 AM, showed Resident 148 in the common area of the unit reclined in a lounge chair. The resident was not dressed and still in their night clothes with a blanket covering their lower body. The resident kicked their blanket off several times and attempted to get up, however was unable to related to the chair being in a reclined position which prevented them from rising. During an interview on 06/23/2026 at 11:09 AM, Staff U, Nursing Assistant, (NA), stated that Resident 148 had a rough night was agitated and had refused cares. Staff U stated the resident had been put in (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the lounge chair in the common area to provide enhanced supervision and the resident was unable to get out of the chair once placed in it. Additional medical record review showed Resident 148 had not been evaluated for medical symptoms to justify the use of a pillow under their sheet limiting bed mobility or for the lounge chair which prevented them from rising. The physician had not been notified for orders, or documentation of interventions to include least restrictive alternatives prior to the use of restrictive measures. During an interview on 06/24/2026 at 10:23 AM, Staff B, Director of Nursing, agreed that the pillow used to create a bed barrier and the lounge chair that prevented Resident 148 from rising would be considered restraints and required the appropriate assessments and follow up for use. Reference WAC 388-97-0620(1)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] were not inappropriately placed in nursing homes for long term care) had the required Level 2 referrals sent, or responded to in a timely manner by a licensed mental health professional when residents had a positive Level 1 PASARR for 2 of 5 residents (Resident 14, 97,) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included. Review of the facility policy titled, PASARR Process Revised 03/2019, showed when a Level 2 evaluation was indicated the Social Worker would ensure that a licensed mental health professional was scheduled to evaluate the resident. The Level 2 evaluator would determine if the residents' current care needs were able to be met at the facility and would provide recommendations to be incorporated into the current care plan. Resident 14 Review of Resident 14's medical record showed they admitted to the facility on [DATE] with diagnoses to include an anxiety disorder (a mental health condition characterized by intense, excessive, and persistent worry or fear about everyday situations), depression (a serious mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities), and a psychotic disorder with delusions (a mental health condition where a person experiences a persistent, unshakable belief in something that was completely untrue, even when presented with clear truth). Resident 14's comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired and required the assistance of one staff member for activities of daily living (ADLs). Review of Resident 14's PASARR dated 06/10/2026, showed under Section 1, SMI/ID the resident had two mental health diagnoses marked yes, specifically mood disorder, and an anxiety disorder. A referral for a Level 2 PASARR was required when any questions in Section 1A (1, 2, and/or 3) were marked yes. Review of Resident 14's medical records showed no referral had been sent for the Level 2 PASARR. Resident 97 Review of Resident 97's medical record showed they admitted to the facility on [DATE], with diagnoses including depression and Post Traumatic Stress Disorder ([PTSD], a mental health condition triggered by experiencing or witnessing a terrifying or life-threatening event). Resident 97's comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired and required supervision for ADLs. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 97's PASARR dated 05/29/2026, showed under Section 1, SMI/ID the resident had two mental health diagnoses marked yes, specifically PTSD and other. A referral for a Level 2 PASARR was required if any questions in Section 1A (1, 2, and/or 3) were marked yes. Review of Resident 97's medical records showed no referral had been sent for the Level 2 PASARR. ^ During an interview on 06/23/2026 at 10:08 AM, Staff G, Social Service Director, (SSD) stated they were responsible for ensuring Level 2 PASARR evaluations were completed. Staff B stated a Level 2 referral must be submitted whenever triggers appear on the Level 1 SMI section, and they routinely waited a month after admission to act. Staff B stated they had not sent referrals or follow up regarding Resident 14 and Resident 97 PASARR's. Staff B stated they only performed this task monthly and were trained that the initial determination served as an admission placeholder. Staff B further stated they had not been taught otherwise, and this was why referrals had not been sent out for Resident 14 and Resident 97. Staff B stated residents would then receive services when the Level 2 was completed when warranted. During an interview on 06/30/2026 at 2:40 PM, Staff G stated they had recompleted a lot of the older PASARR's in April and May of 2025 when they first became employed at the facility as many of the long-term care resident's PASARRs had previously been completed incorrectly and required updating. Staff G stated once the PASARR's had been completed correctly, they were then sent to the contracted agency, though often they did not get a timely response back from them, if at all. Staff G stated in conversations they had with the owner of the PASARR contracted agency, they were backlogged in getting the assessments completed. Staff G stated they had a list of residents that required an assessment for a Level 2 PASARR and the referrals were sent to the contracted agency. Staff G stated they realized some of the referrals for a NOD were a year or more out and still had not been completed and they needed to talk with the facility Administrator about setting up a system to get an answer back from the agency in a timely manner so the residents could get the resources they needed for their SMI or ID/DD diagnoses. Reference WAC: 388-97-1915 (1)(2)(a-c)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident received treatment and services in accordance with professional standards of practice regarding implementation of resident directed care and treatment for a resident with a urostomy (a surgical opening in the abdomen that allows urine to exit through a stoma [an artificial opening] in a collection bag) for 1 of 2 residents (Resident 148) reviewed for quality of care. This failure placed residents at an increased risk for unidentified complications and a deterioration in their health status. Findings included . Review of an article in the American Journal of Nursing titled, Nursing Care for Patients after Urostomy Surgery, June 2024, volume 124, showed urostomy care included emptying the drainage bag daily or when full, every three to seven days, clean around the stoma, monitor and provide skin care and change the pouching system to avoid leakage and skin damage. Resident 148 Review of the Resident 148's medical record showed they were admitted with diagnoses which included history of bladder cancer with a urostomy, dementia (a decline in mental functioning) and Parkinson's disease (a progressive disease that damages nerve function). The comprehensive assessment dated [DATE] showed Resident 148 was cognitively impaired and required substantial assistance from staff for dressing, toileting activities, grooming and mobility. Review of Resident 148's history and physical dated 06/13/2025 showed the resident was admitted to the facility with a urostomy for urinary elimination needs. Review of the June 2026 physician orders showed no identification, or treatment interventions to ensure appropriate care was provided. Review of the progress notes from 06/13/2026 to 6/24/2026 showed no assessments or documentation that consistent licensed nursing care had been provided for 11 days since the resident's admission to the facility. During an interview on 06/23/2026 at 11:46 AM, Resident 148's representative stated they were required to provide urostomy care at least three times weekly when the resident had lived at home and they had been responsible for their care. During an interview on 06/24/2026 at 10:16 AM, Staff Y, admission Nurse, stated the resident was admitted on a weekend by a different nurse. Staff Y reviewed Resident 148's medical record and stated they could not find any physician or treatment orders to provide care for the resident's urostomy. Staff Y further stated their process for the use of any type of catheter was to obtain treatment orders for follow up care. During an interview on 06/24/2026 at 10:23 AM, Staff B, Director of Nursing, stated that the expectation on admission for a resident with a urostomy was to ensure the resident received appropriate treatment and had physician orders. Reference WAC 388-97-1060(1)(2)(3)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure restorative (RNP-a specialized program to help long term care residents maintain or improve their maximum functional independence)nursing services programs were implemented for 1 of 4 residents (Resident 34), reviewed for restorative nursing and limited range of motion (ROM-the extent the joint can move within the expected [normal] range of values). This failure placed the residents at risk for loss of ROM, deconditioning, pain, and contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included .Review of an undated facility policy titled, Restorative Nursing Program, showed residents would receive restorative nursing care to help promote optimal safety and independence. Residents may start on a RNP upon admission, during their stay, or when discharged from skilled therapy services. Restorative goals and objectives were to be individualized and placed in the resident's care plan. Resident 34Review of the medical record showed the resident admitted with diagnoses including chronic obstructive pulmonary disease (COPD- a long-term lung disease that made it hard to breathe) and congestive heart failure (CHF- a condition where the heart muscles become too weak or stiff to pump blood effectively). The 05/28/2026 comprehensive assessment showed Resident 34's cognition was intact and required the assistance of two staff members with activities of daily living and had an impairment to their lower extremities. The assessment further showed Resident 34 had no RNP in place. An observation and concurrent interview on 06/21/2026 at 11:12 PM, showed Resident 34 lying in bed with limited ROM to the left arm. Resident 34 stated they wanted exercises and felt forgotten and overlooked. Resident 34 stated they performed exercises as much as they could themselves and added that they would like to have someone lift their legs and bend their joints. An observation and concurrent interview on 06/23/2026 at 9:36 AM, showed Resident 34 lying in bed. Resident 34 stated they used to go to the gym but no longer received any exercise. Resident 34 stated, they would like to have ROM exercises done with their left arm. An observation and concurrent interview on 06/24/2026 at 4:06 PM, showed Resident 34 lying in bed. Resident 34 demonstrated how they tapped their legs to try and exercise and stated they used to have an exercise band but no longer knew where it was. An observation and concurrent interview on 06/25/2026 at 11:33 AM, showed Resident 34 lying in bed. Resident 34 could only actively lift their left arm midway; however, with assistance, the arm could be stretched further. Resident 34 stated they did not want to lose their mobility and wanted to be able to do their hair. Resident 34 demonstrated their range of motion by using their unaffected hand to assist their left arm to move further. The resident stated, My legs too, I need help because I can not keep my left leg bent without help, and I can not do good ROM by myself to strengthen them. Observation of the resident's lower extremities showed they were able to move both legs but could not maintain them in a fixed position without assistance. Review of Resident 34's care plan, dated 06/02/2026, showed there were no RNP's, floor maintenance program (FMP-a program for long term care residents that focuses on maintaining the resident's current level of functioning) or interventions in place. Review of Resident 34's task record from January 2026 to June 2026, showed no active RNP's, FMP's or individualized ROM interventions had been logged by nursing assistants. During an interview on 06/24/2026 at 3:37 PM, Staff P, Licensed Practical Nurse (LPN), stated that Resident 34 had not showed up on my radar for restorative services. Staff P stated that therapy typically referred residents to them. Staff P stated they did not know why Resident 34 was not on an FMP and directed the responsibility to Staff F, Resident Case Manager (RCM). Staff P stated that residents must show (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/25/2026
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a decline to qualify for RNP's. During an interview on 06/24/2026 at 3:46 PM, Staff F, RCM stated they were unaware Resident 34 desired restorative services. Staff F stated the facility previously had the resident on an RNP, but it was discontinued by Staff P. Staff F stated they did not know why the program was discontinued, no transfer documentation was provided to explain why it was stopped. Staff F stated Resident 34 was in bed most of the time and would benefit from an FMP. During an interview on 06/24/2026 at 4:35 PM, Staff B, Director of Nursing, stated that RCMs were responsible for following up on the implementation of RNP's after therapy discharge. Staff B stated all residents were to be evaluated for restorative needs quarterly by the RCMs, and Resident 34 should have been assessed for an RNP or FMP during their quarterly assessment. Reference: WAC 338-97-1060 (1) (2)(b)(3)(d)		

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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	
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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to explain the arbitration agreement (a legal document that required the use of a third party to resolve a dispute) in its entirety, including the right to cancel the agreement within 30 calendar days, in a manner and language that the resident understood for 2 of 3 residents (Resident 138, and 2) reviewed for binding arbitration. This failure placed the residents at risk for losing legal protection, lack of understanding of the legal document, and the right to a jury or court hearing. Findings included. Review of a facility policy titled, Binding Arbitration Agreements, dated 11/2023, showed that in the event of a dispute the resident would waive their right to a jury by trial in the federal or state court system and that the resident or their representative acknowledged full understanding of the arbitration agreement. The facility would explain the agreement to the residents or representatives that ensured their understanding of the arbitration agreement, in a form and manner they understood with consideration of their language, literacy and preference for learning. Additionally, the residents or representatives were provided 30 days after signing the agreement to review and rescind the agreement. Resident 138 Review of the medical record showed Resident 138 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain condition that causes confusion and memory loss), sepsis (a severe infection that affects organs and tissues) and weakness. Review of a Social Services progress note, dated 06/19/2026, showed Resident 138 was not able to make their own decisions due to their cognitive impairment, and their family was involved for decision making. Review of Resident 138's arbitration document titled, Alternative Dispute Resolution Agreement Between Resident and Facility, dated 06/19/2026, the arbitration document was electronically signed by Resident 138 on 06/19/2026 and showed that no legal representative for the resident had signed the binding agreement. Additionally, Staff . Admissions Assistant, signed as the facility's authorized agent. During an interview on 06/21/2026 at 1:02 PM, Resident 138's Representative, (RR), stated they were the residents Power of Attorney (POA-legal representative to make decisions and sign documents for the resident's care) and were not aware of an arbitration agreement from the facility or that Resident 138 had signed an agreement. RR stated no staff members discussed the arbitration agreement with them, and they were unaware of what arbitration was or the ability to rescind an agreement. Resident 2 Review of the medical records showed Resident 2 was admitted to the facility on [DATE] with diagnoses including left leg and arm fractures, diabetes (excess sugar in the blood) and high blood pressure. The 05/05/2026 comprehensive assessment showed Resident 2 had an intact cognition. Review of Resident 2's arbitration document titled, Alternative Dispute Resolution Agreement Between Resident and Facility, dated 04/29/2026, showed the arbitration document was electronically signed by Resident 2 on 04/29/2026 and Staff . Admissions Assistant, signed as the facility's authorized agent. During an interview on 06/21/2026 at 3:57 PM, Resident 2 stated they did not know what arbitration was. Resident 2 stated they were also unaware they had signed an arbitration agreement or that they were able to rescind within 30 days. Resident 2 stated when they had admitted they were not thinking about documents they had signed. During an interview on 06/24/2026 at 3:32 PM, Staff R, Admissions Assistant, stated they were responsible for explaining arbitration agreements to residents. Staff R stated they told residents when or if they have a dispute that they could take the facility to court for, that arbitration was a faster process. Staff R stated they did not read the entire arbitration agreement to the residents and/or representative they only summarized. Staff R stated they had not read the (continued on next page)		

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 06/25/2026
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)		
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arbitration agreement themselves and were not aware of the residents' right to rescind the agreement within 30 days after they signed. During a concurrent interview and record review on 06/24/2026 at 3:41 PM, Staff S, admission Director, stated they were responsible for overseeing the admissions and arbitration agreements. Staff S stated Staff R was responsible for reading and reviewing the arbitration agreements for residents and representatives to understand. Staff S accessed their computer screen to review an arbitration agreement, and stated residents had 30 days to rescind the agreement. During an interview on 06/24/2026 at 4:31 PM, Staff A, Administrator, stated arbitration was a way they helped disputes with residents/representatives be resolved outside a court process and could be rescinded within 30 days. Reference WAC: 388-97-1620(2)(b)(i)		