

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/05/2013
FORM APPROVED
OMB NO. 0938-0391

1050

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2013
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NAME OF PROVIDER OR SUPPLIER SUNSHINE GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE EAST 10410 NINTH AVENUE SPOKANE, WA 99206
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Sunshine Gardens - Spokane on 06/10/2013, 06/11/2013, 06/12/3013, 06/13/2013, 06/14/2013, and 6/20/2013. A sample of 32 residents was selected from a census of 68. The sample included 20 current residents and the records of 10 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., B.S.N. ██████████, R.N., B.S.N. ██████████, B.S.W. ██████████, R.N., B.S.N. ██████████, R.N., B.S.N., M.N. ██████████, M.S.W.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit A Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p>Residential Care Services _____ Date _____</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined, the facility failed to provide medically-related social services for 1 resident (#38) in a sample of 32 related to depression and adjustment to the facility. Findings include: Resident # 38 had diagnoses including [REDACTED] and a [REDACTED]. The resident required extensive assistance with most activities of daily living and had some problems with his memory at times. Per the initial social service assessment completed on 4/10/13, the resident was noted to have severe [REDACTED] and stated he felt bad about himself. The resident's family member stated the resident had been depressed since his [REDACTED] two years ago. During the assessment, the resident said he had thoughts that he would be better off dead and felt like he was a burden on everyone. He admitted he had thought about hurting himself and stated he didn't feel useful about anything. The most recent plan of care for alteration in mood related to the [REDACTED] included goals for being content with nursing home placement and maintain his ability to choose activities, and express satisfaction with leisure opportunities. Interventions included monitoring the resident's mood, social services consult, mental health</p>	F 250		7/31/13

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F 250	<p>Continued From page 2</p> <p>consult, and to listen attentively to the resident when talking about loss.</p> <p>Per record review, the resident was started on an antidepressant medication on 4/23/13.</p> <p>Per social services note on 5/1/13, the resident continued on the medication for [REDACTED] and at times refused showers. However, there was no immediate follow-up completed by social services related to the resident's comments about hurting himself and feeling useless. In addition, there was no long-term plan put in place to provide emotional support for adjustment and management of [REDACTED].</p> <p>Per the social service note dated 5/7/13 the resident continued to show moderate to [REDACTED] [REDACTED] had little pleasure in doing things, felt depressed, tired, useless, and continued to have thoughts he would be better off dead. Social service noted that supportive counseling was provided on that date.</p> <p>Per interview on 6/13/13 at 10:30 a.m., the resident said he needed to stay at the facility because his wife couldn't care for him anymore. The resident said he was trying to adjust to the facility.</p> <p>In an interview on 6/17/13 at 1:30 p.m., Staff #D stated she was the social worker assigned to the resident currently however, the other social services staff (#E) was more knowledgeable about the resident as he was on her side before. Staff #D stated the only communication she had involving the resident was with the resident's wife but it was not regarding his adjustment or mood.</p> <p>In an interview on 6/17/13 at 2:00 p.m., Staff #E stated the resident was very [REDACTED] when he came into the facility, then he went through a</p>	F 250		

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F 250	Continued From page 3 period when he was very confused. When asked what kinds of services were provided to the resident, Staff #E said she provided supportive counseling for the resident as noted on 5/7/13. Staff #E said she had not had much contact with the resident's family regarding his [REDACTED] and adjustment issues. She stated when the resident moved to the other part of the facility he was assigned to the other social services staff (#D). The resident's [REDACTED] was identified on the initial assessment. The resident was started on an [REDACTED] then it was increased. From 4/6/13 to 6/14/13 there was one note in the record indicating supportive counseling was provided, though the resident had made statements that he was better off dead. The record did not show that ongoing emotional support and monitoring of the resident's adjustment to the facility was provided for the resident which placed him at risk for an increase in depression and decreased quality of life.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide necessary	F 309		7/31/13

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F 309	<p>Continued From page 4</p> <p>care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 1 of 10 residents reviewed for bowel management (#135) in a sample of 32. Findings include:</p> <p>The facility bowel program included interventions to give bowel medication if no bowel movement (BM) after 6 shifts (2 days), and again on the 9th shift (3 days).</p> <p>If no BM after 10 shifts, Licensed staff were directed to perform a bowel assessment, notify the physician, legal representative, and obtain orders for additional medication and/or an X-Ray. Per record review, Resident #135 had out-patient treatment for [REDACTED]. The physician orders for [REDACTED] included a softener, as needed fiber supplement, and as needed [REDACTED].</p> <p>Per record review, on 4/25/13 the resident was readmitted from the hospital. The resident's last BM was in the hospital on 4/24/13.</p> <p>Review of the resident's bowel records and nurse's notes revealed the resident did not have a BM from 4/24/13 until 4/29/13 on the evening shift (5 days).</p> <p>Review of the April 2013 medication administration record (MAR) revealed licensed nurses administered a [REDACTED] on 4/27/13 and 4/28/13. There was no result/effectiveness and/or bowel assessment documented on either the MAR or nurse's notes for 4/27/13 (9 shifts/3 days).</p> <p>The nurse's note dated 4/28/13 at 10:35 p.m. revealed the resident was [REDACTED] and given a [REDACTED], with no information as to the results/effectiveness (12 shifts/4 days).</p> <p>A nurse's note dated [REDACTED]/13 at 7:39 p.m. revealed the resident returned from out-patient</p>	F 309		

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F 309	Continued From page 5 treatment and vomited a large amount that was positive for blood. Upon lying down, the licensed nurse noted the presence of stool and administered a [REDACTED] prior to the resident being transported to the hospital for treatment for the bleeding. Review of hospital records dated 4/30/13 revealed in addition to other medical problems, the resident was [REDACTED]. After review of the resident's record on 6/14/13 at 10:25 a.m., Staff #C stated she heard the resident refused [REDACTED] the week of 4/25/13 and had no explanation for the documentation showing the [REDACTED] given with no results or bowel assessment on 4/27/13 and 4/28/13. She confirmed the staff should have followed the bowel protocol. The facility's failure to consistently monitor/evaluate for symptoms of [REDACTED] and accurately document treatment provided placed the resident at risk for untreated [REDACTED].	F 309			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325			

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F 325	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed did not ensure accurate weight measurement and nutritional monitoring/referral/careplanning documentation and follow through for 1 of 3 residents (#38) reviewed for nutrition in a sample of 32. Findings include:</p> <p>Resident #38 had diagnoses of [REDACTED], [REDACTED], and [REDACTED]. Per record review, the resident required supervision and set up with eating and had some difficulty with decision-making and memory impairment. The resident's admission weight on [REDACTED] 13 was 190.</p> <p>Per the nutritional assessment dated 4/24/13, the resident's weight was 178 (12 pound loss). The resident required 1800-2000 calories per day and was taking in an average of 500 calories per day (27% of daily needs.) Recommendations included a referral to the nutrition at risk committee (NAR), supplements at breakfast and lunch, and fortified foods.</p> <p>Per the most recent nutrition care plan, the resident's preferences were listed and the goal was for the resident to eat at least 75% of meals. There was no documentation regarding supplements being ordered.</p> <p>Per review of the weight flow sheet, on 5/15/13 the resident's weight was 172 and on 5/29/13 his weight was 170.</p> <p>There was no documentation found in the record to show the resident was referred and reviewed by the Nutrition At Risk (NAR) committee for his continued weight loss and poor intake.</p> <p>Per review of the meal monitors since admission, the resident was noted as either refusing supplements or documented as not</p>	F 325		

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F 325	Continued From page 7 having a supplement provided. The resident's intake for meals was either refused or 25-50%. Per telephone interview on 6/13 at 8:45 a.m., the Registered Dietician (RD) said she was on leave and hadn't been in the building to review residents for the past month. The RD also stated the information about a resident's supplements should be in the plan of care noting specifically what kind of supplement the resident preferred and should receive. Per interview on 6/13/13 at lunch with Staff #J, who worked with the resident on the day shift, the resident did not receive a nutritional supplement at breakfast and lunch, though the assessment on 4/24/13 documented the resident was to start supplements. Staff #J went on to say the resident did not eat well and could probably benefit from a supplement and that she would start getting him one at meals.	F 325			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		7/31/13	

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F 329	<p>Continued From page 8 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure 1 of 10 residents (#119) in a sample of 32 were free from unnecessary medication, related to inadequate monitoring. This failure put the resident at risk for unknown effectiveness and untreated insomnia. Findings include:</p> <p>Resident #119 had a physician's order for [REDACTED] 25mg for a diagnosis of [REDACTED] on 01/11/13.</p> <p>Per the most recent plan of care for the use of [REDACTED] for sleep directed staff to monitor the resident's sleep patterns. However there was no documentation to show this was being done.</p> <p>Per record review, a Mental Health care conference held 05/10/13 requested the resident's sleep patterns be monitored. As noted above, there was still no documentation found for monitoring effectiveness of sleep medication or it's side effects since the start of the medication on 01/11/13.</p> <p>Nursing communication with the physician dated 5/29/13 and 6/14/13 revealed requests for additional sleep medication, because the resident stated she was not sleeping.</p>	F 329		

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F 329	Continued From page 9 Per interview with on 6/14/13 at 2:50 p.m., Staff A stated the tracking of a residents sleep would be found in care tracker (a charting system used by nursing assistants). Nothing was found for resident #119 regarding sleep in care tracker. Per interview on 6/14/13 at 3:00 p.m., Staff F stated she does not keep track of Resident #119's sleep and she has never tracked it on any other resident. She was not sure of how it would be monitored in care tracker. The facility failed to monitor the effectiveness of the sleep medication. This placed the resident at risk for untreated insomnia.	F 329			
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide services from outside resources as identified in the Level II Preadmission Screening and Resident Review for 1 of 2 residents (#103) reviewed for Level II services. Findings include: Resident #103 had diagnoses of a [REDACTED]	F 406		7/31/13	

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F 406	<p>Continued From page 10</p> <p>and was originally admitted to the facility in [REDACTED] of 2009. The resident had symptoms of her [REDACTED] including [REDACTED], [REDACTED] and issues with [REDACTED].</p> <p>Per record review, the resident had a Level II assessment completed on 2/4/2010 which made the following recommendations for quality of care for the resident in the nursing facility:</p> <ul style="list-style-type: none"> -continue with previous [REDACTED] provider (prior to admission to long term care) if possible and if not possible then update the new [REDACTED] provider with the resident's information. <p>Recommendations also included the resident should receive case management services, consultation as needed, and [REDACTED] medication evaluation and management.</p> <p>Per record review, the resident was reviewed by a mental health practitioner on 11/1/10, and 2/25/11. The resident was also seen in the facility on 2/20/12 secondary to an increase in [REDACTED]. After February of 2012 there were no additional psychiatric services provided for the resident.</p> <p>Per mental health care conference note dated 7/27/12, the resident had ongoing weight loss secondary to a [REDACTED]. There was no information regarding resident's mental health status or possible correlation between the resident's weight loss secondary to [REDACTED] and need for referral for services. The mental health care meetings included the medical director, social services director and at times other disciplines from the facility.</p> <p>Per social service note dated 9/20/2012, resident had ongoing [REDACTED] and continued to lose weight. Record review revealed there was no evidence of referral to mental health at that time.</p> <p>Per care conference note on 2/14/13, resident had increase in [REDACTED] and decreased intake of</p>	F 406		

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F 406	<p>Continued From page 11</p> <p>food secondary to delusions. No recommendation for referral to a psychiatrist was made until the physician recommended it on 3/22/13.</p> <p>Per progress note dated 4/26/13, the resident was noted to have continued weight loss of 10 pounds in the last month and on 5/23/13 a care conference note revealed the resident had another 6 pound weight loss in the last month. Staff were unable to redirect the resident into eating her meals.</p> <p>Per interview on 6/27/13 at 3:00 p.m., Staff #B confirmed the resident was initially seen by a mental health practitioner in the facility but for the last year and a half did not have a mental health practitioner who would visit the resident in the facility.</p> <p>The facility was aware the resident required ongoing mental health services upon admission to the facility in 2009. The facility identified the resident had [REDACTED] and [REDACTED] as well as ongoing weight loss secondary to the signs/symptoms of her [REDACTED]. The level II made recommendations for ongoing services by a mental health practitioner and the facility did not ensure the services were provided placing the resident at risk for decreased quality of life.</p>	F 406		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>	F 431		7/31/13

IDR AMENDED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2013
NAME OF PROVIDER OR SUPPLIER SUNSHINE GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE EAST 10410 NINTH AVENUE SPOKANE, WA 99206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 12</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 3 of 3 medication carts on the south wing were consistently locked when unattended by licensed nurses. Failure to consistently secure medications potentially allowed residents and visitors in the south wing of the facility access to potentially harmful medications. Findings include: On 6/11/13 at 10:20a.m. the medication cart located on Peach Tree Unit was unlocked with no</p>	F 431		

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F 431	Continued From page 13 staff in sight. Staff #F was informed and the cart was locked. On 6/11/13 at 1:03p.m. the medication cart for Serenity was in front of main nurses' station unlocked, no staff was present. Staff #D was informed of the unlocked cart and cart was locked. On 6/14/13 at 11:50a.m. medication cart was on Alpine unlocked, no staff in sight. Staff #H returned and locked the cart.	F 431			

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