

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

PRINTED: 02/19/2014
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 01/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216
--	---

(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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Sullivan Park Care Center on 1/21/14, 1/22/14, 1/23/14, 1/24/14, 1/27/14. A sample of 35 residents was selected from a census of 116. The sample included 27 current residents, and the records of 8 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Jessica Dingwall, M.S.W. Mara Ryan, B.S.W. Jessica Wolfrum, R.N. Lisa Harting, R.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit A 316 W. Boone Avenue, Suite 170 Spokane, Washington, 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>L. Harting</i> 2/19/14 Residential Care Services Date</p>	F 000		<p>W 2/15/14</p>
-------	---	-------	--	----------------------

RECEIVED
FEB 25 2014
DSHS AD SA RCS
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 2/24/14
---	------------------------	----------------------

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.

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 01/27/2014
NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216		
(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 253 SS=D	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain resident recliners in a sanitary and comfortable manner for 5 of 6 units (100, 200, 400, 500 and 600 hall). This caused a lack of sanitary and homelike environment. Findings include:</p> <p>On 1/27/14 at 1:00 p.m., recliners which are located in the common areas of each unit were observed with the following findings:</p> <ul style="list-style-type: none"> -In the 100 hall: a recliner had dried, white spots on the side and front. -In the 200 hall: a yellow recliner had a crusted, food like substance on the seat, the arms were soiled with dirt, and there was a hole on the top. A Tan cloth recliner had blackened arms. A brown, leather recliner had torn areas on the side. -In the 400 hall: a maroon recliner had dried substance. -In the 500 hall: a brown recliner had several dried, crusted substances on the arm and seat of the chair. Another recliner had pinkish spills on the arms of the chair. -In the 600 hall: a green recliner had a dried, food like substance on the arm of the chair and a brown recliner had dried, food like substances on the arm of the chair and down the side. <p>On 1/27/14 at 2:25 p.m., Staff #A stated staff that work on those units should let housekeeping</p>	F 253	<p>F253- All recliners with stains were cleaned. All recliners with tears or holes were removed from the facility. The Housekeeping supervisor will do weekly checks of all the recliners to check for cleanliness and need of repair. Recliners beyond repair or cleaning will be discarded. Staff was educated to observe recliners for cleanliness or repair and how to report them to the Housekeeping Supervisor. The Administrator will monitor on daily rounds for the above issues. The facility</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216
--	---

(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 253	Continued From page 2 know when recliners are dirty. When it is needed they contact a local company to come in and steam clean them. The last time some of the recliners were cleaned were several months earlier.	F 253	will be in compliance on March 15 th , 2014. The Administrator and Housekeeping Supervisor will monitor to ensure compliance.	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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 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</p>	F 329		

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 01/27/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216
---	---

(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 329 Continued From page 3
adequately monitor psychoactive and blood pressure medications for 2 of 5 residents (#145, 163) in a sample of 35. Findings include:

1. Resident #145, per record review, had diagnoses that included [REDACTED].

Per review of a psychotropic drug assessment dated 4/16/13, the facility attempted to discontinue the resident's [REDACTED] on 2/6/13, however, the resident began having increased delusions and increased worrying and was restarted on the [REDACTED] on 4/11/13.

Per review of the Medication Administration Record (MAR), the resident was on [REDACTED] 2.5mg daily to treat her [REDACTED] disorder. There was no documentation of adverse side effect being monitored for the [REDACTED].

During an interview on 1/27/14 at 11:45 a.m., Staff #B stated the adverse side effects for psychotropic medications are monitored on the MAR. After reviewing Resident #145's MAR, he confirmed that the [REDACTED] was not being monitored for side effects.

On 1/27/14 at 1:30 p.m., Staff #C confirmed side effects were not being monitored for the resident.

Failure of the facility to monitor the resident on [REDACTED] placed the resident at risk for clinically significant adverse side effects.

2. Resident #163, per record review, had diagnoses that included high blood pressure.

Record review revealed a physician order for [REDACTED] a medication to control high blood pressure. The order included instructions for the licensed nurse to "hold for SBP (systolic blood pressure) less than 100." Documentation on the MAR for January 2014 showed there were no

F 329 Nurse responsible for the monitoring sheet was educated on its importance at the time of survey.

Resident #163 had their blood pressure taken at the time of survey (was found to be in normal limits). Blood pressures were found on the vital signs sheet. Residents parameters were discussed with the residents medical provider and new orders were received.

Licensed Nurses were educated on the importance of side effects monitoring for

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 01/27/2014
NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216		
(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 329	Continued From page 4 blood pressures documented for 14 days out of a possible 27. The MAR for October and November 2013 had no documented blood pressures. Per review of the vital sign flow sheet, blood pressures had only been done 3 times in October and 3 times in November. During an interview on 1/27/14 at 1:40 p.m., Staff #D stated that if the blood pressures weren't written on the MAR than they may be found on the vital sign flow sheets. Failure to monitor the resident's blood pressure prior to giving a medication to control high blood pressure placed the resident at risk for receiving unnecessary medication.	F 329	antipsychotic medications and to ensure any medication that requires a blood pressure check be done prior to administering that medication. Resident Care Managers will do bi-weekly audits for side effect monitoring sheets and blood pressure checks for medications requiring them. The DNS will evaluate audits and do any follow-up education for any discrepancies found. The corrective action will be in place by March 15 th , 2014. The Administrator and DNS will monitor for compliance.		