

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

PRINTED: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

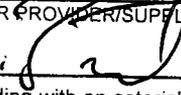
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2013
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NAME OF PROVIDER OR SUPPLIER SPOKANE VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 222 EAST FIFTH SPOKANE, WA 99202
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Spokane Veteran's Home on 5/02/13 and 5/03/13. A sample of 6 residents was selected from a census of 95. The sample included all current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2788305 #2788274</p> <p>This survey was conducted by: [REDACTED], BSW</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit A 316 West Boone Ave., Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p> Residential Care Services Date 5/23/13</p>	F 000	<p>RECEIVED MAY 29 2013 DSHS SPOKANE, WA</p>	6/14/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 5/29/13
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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 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to operationalize policies and procedures for abuse prohibition related to the reporting of incidents of potential abuse/neglect for 2 residents (#1, 2) in a sample of 6. Findings include:</p> <p>Per review of the facility abuse policy/procedure, all incidents of alleged or suspected abuse or neglect are to be reported and investigated in accordance with established federal and state rules. Any employee witnessing an incident of resident mistreatment, abuse or neglect, or having reasonable cause to suspect such an occurrence must report the incident or suspicion to the licensed nurse. The employee can request assistance from the licensed nurse to evaluate the need to protect the alleged victim from futher harm and to place a call to the state abuse hotline.</p> <p>1. Resident #1 had diagnoses that included [REDACTED]. Per record review, the resident had short and long term memory impairment and required assistance with decision making. Per the facility investigation, the resident asked staff for a phone number while he was up</p>	F 226		

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in the middle of the night on 4/10/13. Staff #A yelled at the resident and later told Staff #B "these guys don't need to be up roaming around at this hour and I already told him I couldn't give him the number a few days ago." Staff #B reminded Staff #A that many of the residents at the facility don't remember things and many of them are up at all hours of the night. Staff #C wrote a statement that the resident was upset and she had to bring him back to his room and calm him down after the incident.

In an interview on 5/3/13 at 10:30 a.m., Staff #D said she witnessed Staff #A yell at Resident #1 at least 3 or 4 times in the past regarding his questions about using the phone. Staff #D said she witnessed him crying and very upset at times after asking to use the phone. When asked if she reported the incidents, Staff #D said no she took care of it herself.

The facility's failure to report incidents of potential verbal abuse by staff toward the resident placed the resident at risk for ongoing abuse.

2. Resident #2 had diagnoses that included history of a [REDACTED], [REDACTED], [REDACTED] and [REDACTED] above the [REDACTED]. The resident required total assistance with all activities of daily living and was not able to get out of bed secondary to his medical condition. The resident was alert and oriented and able to make his needs known.

Per the facility investigation, on 4/8/13 the resident's family member reported that Staff #A told the resident it was ridiculous that he had to take his pills in the [REDACTED] and there was no reason why he couldn't swallow his medications whole. Staff #A also made comments that he was going to get his [REDACTED] discontinued.

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F 226	<p>Continued From page 3</p> <p>The resident's family member also reported that the resident felt he was being targeted related to the volume of his television.</p> <p>The investigation included an interview with the resident by the social worker. The resident stated that in recent months Staff #A had become fixated on his television and the volume. The resident said Staff #A became "irate" with him and "was almost on the edge of being abusive."</p> <p>In an interview on 5/2/13 at 1:30 p.m., the resident said in the last several months Staff #A changed, one day he was okay with you and the next day he was angry. The resident said Staff #A made threats about his television being on during the night and made the nursing assistants leave his room before making the threats. The resident said Staff #A told him it was his word against the resident's. The resident said he was afraid to go to sleep at night sometimes because of Staff #A. The resident said he did not report this to anyone because he was afraid of retaliation from the staff member.</p> <p>In an interview on 5/3/13 at 10:30 a.m., Staff #D reported she heard Staff #A say inappropriate things to Resident #2 in the past. Staff #D said she felt it was belittling the resident and disrespectful. However, when asked if she reported this she said no she didn't report it and did not work with Staff #A very often anymore. Staff #D said she did not want to be in Resident #2's room alone with Staff #A because it would be her word against his.</p> <p>The facility's failure to report incidents of potential verbal abuse placed the resident at risk for ongoing abuse.</p>	F 226		
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