

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

PRINTED: 01/14/2015
FORM APPROVED
OMB NO. 0938-0391

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 12/31/2014
NAME OF PROVIDER OR SUPPLIER SPOKANE VETERANS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 222 EAST FIFTH SPOKANE, WA 99202		
(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 Abbreviated Survey conducted at Spokane Veteran's Home on 12/31/14. A sample of 4 residents was selected from a census of 98. The sample included 4 current residents.</p> <p>The following were complaints investigated as part of the survey:</p> <p>#3057381</p> <p>The survey was conducted by:</p> <p>Jessica Dingwall, MSW</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long Term Support Administration Residential Care Services, District 1, Unit A 316 W. Boone Avenue Suite 170 Spokane, WA 99201-2351 Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p><i>Cindy Caldwell</i> 1/13/15 Name Date</p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">JAN 21 2015 - <i>SST</i> <i>1/22/15</i></p> <p style="text-align: center;">DSHS ADSA RCS SPOKANE WA</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Betty Rodriguez</i>	TITLE <i>AKI, DMS</i>	(X6) DATE <i>1-22-15</i>
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to report, as required by CFR 483.13 (c)(2)(3)(4), or thoroughly investigate, an incident of a missing resident, and misappropriation of a resident's personal property, for 2 of 4 residents (#1, 2) reviewed. Findings include.</p> <p>1. Resident #2 had been admitted to the facility on [REDACTED]. Per the record, the resident was independent with propelling his wheelchair, and had poor safety awareness.</p> <p>On 12/20/14, the resident left the facility for an unknown destination, without informing staff. The facility was unaware the resident had left, or his location, until the Spokane Transit Authority called to alert them the resident had been removed from the bus at the bus plaza, after being identified as unable to safely ride the bus.</p> <p>The state reporting log, as well as the investigation of the incident, were reviewed. The facility did not call the state survey and certification agency, to report the elopement, as required. In addition, the investigation of the incident was not thorough. There was no determination made as to how long the resident was gone, how he was able to leave the facility and get to the bus stop, if he informed staff he was leaving, and other key pieces of information which were pivotal to the investigation.</p> <p>On 12/31/14 at 1:30 p.m., Staff #A (a licensed nurse who investigated incidents at the facility) was interviewed. She was unable to answer specific questions regarding the incident. The investigation lacked factual information, and failed to identify how to prevent further occurrences.</p> <p>Staff #B and C, social services staff, were also</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>interviewed. They were unable to recall if a missing resident should be reported to the state survey and certification agency.</p> <p>The facility failed to report a resident elopement/missing resident to the state agency as required, and to thoroughly investigate the incident, in order to determine the most effective preventative measures.</p> <p>2. Resident #1 had diagnoses of [REDACTED]</p> <p>The resident used a wheelchair for mobility, and needed assistance with activities of daily living.</p> <p>The facility abuse policy was reviewed. Misappropriation of resident property was defined as: "deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent".</p> <p>Per the record, on 12/3/14, an incident report noted possible exploitation of Resident #1, and misappropriation of his property. He had a missing shirt, which was found later being worn by Staff #D, while she was working a shift at the facility.</p> <p>Documentation by the facility indicated that on 12/5/14, Staff #D admitted to taking the resident's shirt, wearing it on 9/25/14, and again on 12/4/14. The resident's shirt had been missing for a unknown period of time.</p> <p>On 12/31/14 at 10:20 a.m., Resident #1 was interviewed, and could not recall if he had any missing items. He was not aware of the incident of the missing shirt, or that it was found being worn by Staff #D.</p> <p>On 12/31/14 at 1:30 p.m., Staff #B (a social services staff person) said that prior to the 12/3/14 missing shirt incident, a staff member had told her they saw another staff member</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>wearing Resident #1's shirt. The named staff member wearing the shirt had said "This shirt would look better on me than on Resident #1". Staff #B admitted she did not report any of this information to administration, at the time it was initially reported to her. She said, "now that I think about it, I should have reported it". Staff #B indicated that when questioned, Staff #D had no remorse for taking the shirt, and could not understand why it was a big deal to take a resident's clothing and wear it. Facility staff had knowledge of possible exploitation of a resident, and misappropriation of his property, yet they did not report the incident to the state survey and certification agency as required, or thoroughly investigate the incident when it initially occurred.</p> <p>The incident was investigated, and then reported to the state agency, on 12/5/14. The investigation was reviewed: there was no summary of the incident, no documentation of findings, indication of action taken, no evidence of communication with resident or family, and no evidence the resident was being monitored for psychological harm. 28 days had passed since the initiation of the investigation.</p> <p>The failure of the facility to report, and thoroughly investigate the initial and subsequent incidents in a timely manner, put the resident at risk for further exploitation and/or misappropriation of his personal property.</p>	F 225			