STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

CENTRAL COLUMBIA SENIOR LIVING
THE CAMBRIDGE
301 H ST SW
QUINCY, WA 98848

RE: THE CAMBRIDGE License # 1716

Dear Administrator:

This letter addresses Compliance Determination(s) 33125 (Completion Date 11/28/2023) and 30860 (Completion Date 10/16/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/28/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Elaine Lopez, Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: THE CAMBRIDGE
Provider Type: Assisted Living Facility
License/Cert.#: 1716
Compliance Determination #: 30860
Intake ID: 100902
Investigator: Robin Rainville
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/10/2023 through 10/16/2023
Complainant Contact Date(s):

Allegation(s):
A named resident was given one dose of the wrong medication.

Investigation Methods:

Sample:
Total residents: 22
Resident sample size: 2
Closed records sample size: 1

Observations:
General facility environment
Residents
Dining
Resident rooms
Staff to resident interactions
Medication administration

Interviews:
Nursing staff
Administrator
Residents
Family members

Record Reviews:
Narcotic logs
Medication Administration Records (MARS)
Hospital records
Resident characteristic roster
Medical records
Incident investigation
Facility policies
Personnel files

Investigation Summary:
Record review showed the named resident became ill after receiving the wrong medication and was sent to the hospital. Interviews and record review showed that the named staff member failed to follow the facility's medication policy which caused the medication error. Failed practice identified under WAC 388-78A-2210 reference statement of deficiencies dated 10/16/2023.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 1716	Compliance Determination #:30860
Plan of Correction	THE CAMBRIDGE	Completion Date
Page 1 of 4	Licensee: CENTRAL COLUMBIA SENIOR LIVING	10/16/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 10/10/2023 and 10/19/2023 of:

THE CAMBRIDGE
301 H ST SW
QUINCY, WA 98848

This document references the following complaint number(s): 100902

The following sample was selected for review during the unannounced on-site visit: 2 of 22 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Gwin Kaercher
Residential Care Services

10/26/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Statement of Deficiencies	License # 1716	Compliance Determination # 30860
Plan of Correction	THE CAMBRIDGE	Completion Date
Page 2 of 4	Licensee: CENTRAL COLUMBIA SENIOR LIVING	10/16/2023

Administrator (or Representative) 11/06/2023 Date

Per phone conversation on 11/07/2023. ME

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2260:

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medication was administered as prescribed, for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 receiving a medication that was not prescribed to them. Resident 1 experienced changes in their vital signs, nausea, vomiting, respiratory and cognitive changes. Resident 1 was transferred to the hospital for an adverse drug reaction and fluid in their lungs.

Findings included...

Review of the ALF's, "Medication Assistance," policy, dated 04/28/2023, showed that the staff were to review and ensure that they followed the eight rights of a medication pass which included the right resident, the right medication, and the right time of administration. The policy showed that these rights were to be checked before and after dispensing a medication from its package.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 04/13/2023, showed that the resident required medication assistance from the facility staff and was independent with other activities of daily living. The NSA showed that Resident 1 had diagnoses which included [redacted] and [redacted]

Review of Resident 1's October 2023 Medication Assistance Record (MAR) showed that the resident was prescribed clonazepam (a controlled narcotic medication for anxiety) at 6:00 AM and 6:00 PM.

Review of the facility's narcotic tracking sheet for Resident 1 showed that their clonazepam was not dispensed from the medication card for the 6:00 AM dose on 10/02/2023.

Review of the facility's "Medication Incident Report," dated 10/02/2023 showed that Staff B Medication Technician (MT) had mistakenly given buprenorphine-naloxone (a controlled

narcotic medication used to treat drug abuse) to Resident 1 on 10/02/2023 at 6:10 AM. The report showed that the resident experienced changes in their vital signs, nausea, vomiting, respiratory changes, cognitive changes, drowsiness, and weakness as a result of the error, and was taken to the Emergency Room (ER).

Review of the Federal Drug Administration medication guide for buprenorphine-naloxone dated October 2019 showed that the adverse medication reactions to this medication included headache, nausea, vomiting, pain, and/or numbness, swelling, burning and excess saliva in the mouth. The guide indicated that the medication could cause serious and life-threatening problems and may require emergency help if a person experienced feeling faint or dizzy, confusion, breathing issues or severe sleepiness. The guide also showed a higher risk of death and coma if a person took this medication with other medicines, such as benzodiazepines (such as Clonazepam).

In an interview on 10/11/2023 at 12:10 PM with Collateral Contact 1, Licensed Pharmacist, they stated that buprenorphine-naloxone side effects include in order of prevalence: headache, pain, nausea, vomiting, and abdominal pain.

On 10/10/2023 at 11:05 AM, Staff C, MT, stated that on 10/02/2023 at 7:25 AM, they found that Resident 1's 6:00 AM dose of their clonazepam was still in the medication card, which indicated to them that Staff B had given the wrong medication to Resident 1. Staff C stated that at that same time, a caregiver told them that Resident 1 was vomiting, short of breath, weak, dizzy and confused. Staff C stated that Resident 1 had not been having any symptoms prior to that morning. Staff C stated that they were directed by Resident 1's doctor to send them to the ER.

Review of Resident 1's progress note, dated 10/02/2023 at 6:20 AM, showed that the resident was in the dining room having coffee and visiting with other residents after they had unknowingly received the wrong medication.

Review of Resident 1's progress note, dated 10/02/2023 at 4:50 PM, showed that the resident returned from the ER with diagnoses of [redacted] and [redacted]

Review of Resident 1's progress note, dated 10/02/2023 at 11:15 PM, showed that Resident 1 had been sleeping since they returned from the ER, had not eaten during the evening shift, was shaking and unable to stand on their own.

Review of Resident 1's progress note, dated 10/03/2023 at 6:36 AM, showed that Resident 1 refused their anxiety medication and was confused.

Review of Resident 1's progress note, dated [redacted]/2023 at 11:54 AM, showed that morning Resident 1 had not had anything to eat nor drink since their return from the ER

and their pulse rate was high and their oxygen level was low. The resident was weak and could not stay awake or sit upright. The note showed that Resident 1 was sent back to the ER at the request of their responsible party.

On 10/10/2023 at 11:27 AM, Staff A, Administrator, stated that they investigated the medication error incident. Staff A stated that Staff B told them they felt rushed when giving Resident 1 their medication on [redacted]/2023 at 6:00 AM and did not verify that they had the correct medication card. Staff A stated that the two medications looked similar in size and shape, and that Staff B grabbed the wrong card without following the medication policy. Staff A stated that Resident 1 returned from the ER on [redacted]/2023, but then was still feeling ill on [redacted]2023 so they were sent the ER again. Staff A stated that Resident 1 passed away at the ER on [redacted]/2023.

Review of the hospital records showed that Resident 1's diagnoses upon discharge from the ER on [redacted]/2023 included [redacted] and [redacted]

Review of the hospital records for Resident 1's [redacted]2023 ER visit showed that the resident suffered from aspiration pneumonia (an infection in the lungs from inhaling something other than air, such as food, liquid, vomit, or other foreign particles) and a heart attack. The records showed Resident 1 passed away on [redacted]/2023 at 7:12 PM.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, THE CAMBRIDGE is or will be in compliance with this law and / or regulation on (Date) 10/27/2023

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — 11/6/2023 Date