STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

04/30/2025

PARK VISTA RETIREMENT & ASSISTED LIVING COMMUNITY LLC
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
3425 BOONE RD SE
SALEM, OR 97317

RE: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY # 1810

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 58749 (Completion Date 04/30/2025) and 54502 (Completion Date 02/11/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/30/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

The Department staff who did the On Site verification:
Nikolas Jennings, Community Nurse Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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 follow-up on 02/11/2025 of:
PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
2944 SE LUND AVE
PORT ORCHARD, WA 98366

This document references the following SOD dated: 02/11/2025

The following sample was selected for review during the unannounced on-site visit: 5 of 48 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Residential Care Services — 02/20/2025 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.

Administrator (or Representative) — 2.20.25 Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(a) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person:

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician of resident refusals of medications for 2 of 5 (Resident 1 & 2 [R1 & R2]) sampled residents. This failure resulted in both residents placed at risk for not receiving proper instructions from their medical providers on potential medication side effects or complications due to medication refusal.

Findings included...

Record review of the "Department of Social and Health Services" document, completion date 12/17/2024; showed, "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2240] as stated in the cited deficiencies in the enclosed report. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all

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.

Residential Care Services — 02/20/2025 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.

Administrator (or Representative) — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician of resident refusals of medications for 2 of 5 (Resident 1 & 2 [R1 & 2]) sampled residents. This failure resulted in both residents placed at risk for not receiving proper instructions from their medical providers on potential medication side effects or complications due to medication refusal.

Findings included...

Record review of the "Department of Social and Health Services" document, completion date 12/17/2024, showed, "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC 388-78A-2240] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff A, Executive Director, signed the document on 12/31/2024. Staff A signed the "Plan/Attestation Statement" for all citations cited that read "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 facility] is or will be in compliance with this law and/or regulation on 01/31/2025."

Record review of facility policy titled "Refused Medications" undated showed, "Notification will be provided to the prescribing physician by the MT/QMAP (Medication Technician/Qualified medication administration personnel) when a resident refuses an ordered medication or treatment and follow directions about reporting subsequent refusals."

Record review of the Medication Administration Record (MAR) for R1 dated 02/01/2025 - 02/28/2025 showed clonidine (a medication used to treat high blood pressure) was refused on 02/04/2025, 02/06/2025, 02/08/2025, 02/09/2025, and 02/11/2025. This resulted in five missed doses. Further review showed no documentation of Doctor of Medicine (MD) notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed clopidogrel (a medication used to prevent blood clots) was refused on 02/04/2025, 02/06/2025, 02/09/2025, and 02/11/2025. This resulted in four missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed duloxetine (a medication used to treat depression) was refused on 02/04/2025, 02/06/2025, 02/09/2025, and 02/11/2025. This resulted in four missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed insulin lispro (a medication used to reduce blood sugar) was refused on 02/04/2025, 02/06/2025, 02/10/2025, and 02/11/2025. This resulted in five missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed hydralazine (a medication used to reduce blood pressure) was refused on 02/04/2025, 02/06/2025, 02/09/2025, and 02/11/2025. This resulted in five missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed pantoprazole (a medication used to help with stomach acid) was refused on 02/04/2025, 02/06/2025, 02/09/2025, and 02/11/2025. This resulted in four missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R1 dated 02/01/2025 - 02/28/2025 showed sevelamer carbonate (a medication used to help with phosphorus levels) was refused on 02/04/2025, 02/06/2025, 02/09/2025, and 02/11/2025. This resulted in four missed doses. Further review showed no documentation of MD notification.

Record review of the progress notes for R1 dated 02/01/2025 - 02/28/2025 showed no documentation of MD notification of medication refusals.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed arfmoterol tartrate (a medication used to help with breathing) was refused on 02/01/2025, 02/02/2025, 02/05/2025, 02/06/2025, 02/08/2025, and 02/09/2025. This resulted in nine missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed budesonide (a medication used to help with breathing) was refused on 02/01/2025, 02/02/2025, 02/05/2025, 02/06/2025, 02/07/2025, 02/08/2025, and 02/09/2025. This resulted in 10 missed doses. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed calcium carbonate (a medication used to help with upset stomach) was refused on 02/02/2025. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed cholecalciferol (a medication used to increase levels of vitamin D) was refused on 02/02/2025. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed vitamin B-12 (a medication used to increase levels of vitamin B-12 in the body) was refused on 02/02/2025. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed anastrozole (a medication used to treat breast cancer) was refused on 02/03/2025. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed gabapentin (a medication used to treat nerve pain) was refused on 02/03/2025. Further review showed no documentation of MD notification.

Record review of the MAR for R2 dated 02/01/2025 - 02/28/2025 showed hydralazine (a medication used to decrease blood pressure) was refused on 02/03/2025. Further review showed no documentation of MD notification.

Record review of the progress notes for R2 dated 02/01/2025 - 02/28/2025 showed no documentation of MD notification of medication refusal.

In an interview on 02/11/2025 at 1:18PM with Staff B, Wellness Director, stated that if a medication is refused, they will attempt to give it three times, then dispose of the medication and fax the doctor and power of attorney. Further stated that it was not within the scope of practice of a medication technician to allow for a medication refusal without notifying the doctor.

In an interview on 02/11/2025 at 1:02PM with Staff A, Executive Director, stated that the medication technician should be notifying the doctor of any medication refusal unless otherwise specified by the doctor. Further stated that medication technicians should know to notify the doctor of medication refusals.

This is an uncorrected deficiency previously cited on 12/17/2024.

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, PARKVISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) March 27, 2025

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

Administrator (or Representative) 2.20.25
Date

Record review of the progress notes for R2 dated 02/01/2025 - 02/28/2025 showed no documentation of MD notification of medication refusal.

In an interview on 02/11/2025 at 1:18PM with Staff B, Wellness Director, stated that if a medication is refused, they will attempt to give it three times, then dispose of the medication and fax the doctor and power of attorney. Further stated that it was not within the scope of practice of a medication technician to allow for a medication refusal without notifying the doctor.

In an interview on 02/11/2025 at 1:02PM with Staff A, Executive Director, stated that the medication technician should be notifying the doctor of any medication refusal unless otherwise specified by the doctor. Further stated that medication technicians should know to notify the doctor of medication refusals.

This is an uncorrected deficiency previously cited on 12/17/2024.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 51481
Investigator: Nikolas Jennings
Investigation Date(s): 12/12/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 157346
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Financial Exploitation- Medications went missing and were assumed stolen.
2) Quality of care/treatment- Pain management was insufficient.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Business office manager Executive Director Health and Wellness Director
Record Reviews:	Medical records Hospital records Grievance log Facility policies Personnel files Staff training records Medication Administration Record Negotiated Service Agreement

Investigation Summary:
1) Financial Exploitation- Medications went missing and were assumed stolen. Unclear if the medications missing were due to a pharmacy error, or due to an

intake error by the facility. Facility did not adequately ensure that the medications were obtained in a timely manner. Facility did not ensure that staff were properly vetted to ensure safety of residents. Failed practice identified.

2) Quality of care/treatment- Pain management was insufficient. Facility failed to ensure that the medication to properly manage residents pain was in the building. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 51481
Investigator: Nikolas Jennings
Investigation Date(s): 12/12/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 157059
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Abuse- nonconsensual sexual conduct.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Business office manager Executive Director Health and Wellness Director
Record Reviews:	Medical records Hospital records Grievance log Facility policies Personnel files Staff training records Medication Administration Record Negotiated Service Agreement

Investigation Summary:
1) Abuse- nonconsensual sexual conduct. Facility investigated and found the allegation toward the staff member to be unfounded. Facility failed to notify the department to ensure that proper practices were in place for resident safety. Failed

practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 51481
Investigator: Nikolas Jennings
Investigation Date(s): 12/12/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 150863
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Pharmaceutical services- Facility is failing to provide medications in a timely manner.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Business office manager Executive Director Health and Wellness Director
Record Reviews:	Medical records Hospital records Grievance log Facility policies Personnel files Staff training records Medication Administration Record Negotiated Service Agreement

Investigation Summary:
1) Pharmaceutical services- Facility is failing to provide medications in a timely manner. Facility has put a plan in place to have the resident sign off that they have

received their medications to ensure that there is no issues. Resident reports that following plan being put into place, issues have been resolved. Resident claimed that previously that the facility had marked down medications as refused. Facility failed to notify physician when medications were refused. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 51481
Investigator: Nikolas Jennings
Investigation Date(s): 12/12/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 159049
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Pharmaceutical Services- Medications went missing.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Business office manager Executive Director Health and Wellness Director
Record Reviews:	Medical records Hospital records Grievance log Facility policies Personnel files Staff training records Medication Administration Record Negotiated Service Agreement

Investigation Summary:
1) Pharmaceutical Services- Medications went missing. Unclear if the medications missing were due to a pharmacy error, or due to an intake error by the facility. Facility did not adequately ensure that the medications were obtained in a timely

manner. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
License/Cert.#: 1810
Compliance Determination #: 51481
Investigator: Nikolas Jennings
Investigation Date(s): 12/12/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 159053
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1) Pharmaceutical Services- Medications went missing.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified staff Identified resident Nursing staff Residents Business office manager Executive Director Health and Wellness Director
Record Reviews:	Medical records Hospital records Grievance log Facility policies Personnel files Staff training records Medication Administration Record Negotiated Service Agreement

Investigation Summary:
1) Pharmaceutical Services- Medications went missing. Unclear if the medications missing were due to a pharmacy error, or due to an intake error by the facility. Facility did not adequately ensure that the medications were obtained in a timely

manner. Failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 1810	Compliance Determination # 51481
Plan of Correction	PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY	Completion Date
Page 1 of 8	Licensee: PARK VISTA RETIREMENT & ASSISTED LIVING COMMUNITY LLC	12/17/2024

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 12/12/2024 and 12/13/2024 of:

PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY
2944 SE LUND AVE
PORT ORCHARD, WA 98366

This document references the following complaint number(s): 157346, 157059, 150863, 159049, 159053

The following sample was selected for review during the unannounced on-site visit: 5 of 33 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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.

Jody Just
Residential Care Services

12/18/2024
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.

Administrator (or Representative)

12.31.2024
Date

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

(3) Has received three positive references for the person;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 4 sampled Staff (Staff F and Staff G) had submitted background authorization forms to the department no later than one business day after starting work, and failed to do reference checks for 3 of 4 sampled staff (Staff F, G, & H). This placed all residents at risk of receiving care by an unqualified caregiver.

Findings included...

Record review of Employee list, undated, showed a hire date of Staff F on 01/01/2024 and a hire date of Staff G on 01/11/2024.

Record review of employee background check authorization for Staff F showed a submission date of 05/07/2024.

Record review of employee background check authorization for Staff G showed a submission date of 02/07/2024.

In an interview on 12/12/2024 at 113PM with Staff E, Business office manager, acknowledged the background check authorization dates and stated that there were no reference checks on file for Staff F, Staff G, or Staff H.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 01.31.2025.

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

Administrator (or Representative) 12.31.24 Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to properly notify the physician of resident refusals of medications for 3 of 5 (Resident 1, 2, & 3) sampled residents. This failure placed all 3 residents at risk for not receiving proper instructions from their medical providers on potential medication side effects or complications due to medication refusal.

Findings included...

Record review of facility policy titled "Refused Medications", undated, showed "Notification will be provided to the prescribing physician by the MT/QMAP (Medication Technician/Qualified medication administration personnel) when a resident refuses an ordered medication or treatment and follow directions about reporting subsequent refusals."

Resident 1 (R1):

Record review of Medication Administration Record (MAR) for R1 dated 12/01/2024-12/31/2024 showed Hydralazine (A medication used for blood pressure management) refused on 12/8/2024. Further review showed no documentation of doctor of medicine (MD) notification.

Record review of progress notes for R1 dated 12/01/2024-12/12/2024 showed no documentation of MD notification of medication refusal.

Resident 2 (R2):

Record review of MAR for R2 dated 11/01/2024-11/30/2024 showed Atorvastatin (A medication used for high cholesterol), Donepezil (A medication used to treat dementia), Eliquis (A medication to prevent blood clots) and Latanoprost (A medication for the treatment of glaucoma) refused on 11/01/2024. Further review showed no documentation of MD notification

Record review of progress notes for R2 dated 11/01/2024-12/01/2024 showed no documentation of MD notification of medication refusal.

Resident 3 (R3):

Record review of MAR for R3 dated 11/01/2024-11/30/2024 showed Lidocaine 4% patch (A medication used for pain) refused on 11/06/2024, 11/07/2024, 11/08/2024, 11/12/2024-11/15/2024, 11/19/2024, 11/21/2024, 11/22/2024, 11/23/2024, 11/24/2024, and 11/25/2024. This resulted in 13 missed administrations. Further review of showed no documentation of MD notification of medication refusal.

Record review of MAR for R3 dated 11/01/2024-11/30/2024 showed Arformoterol Tartrate Nebulizer (A medication used to treat COPD) refused on 11/10/2024, 11/11/2024, 11/14/2024, 11/15/2024, 11/16/2024, 11/17/2024, 11/21/2024, 11/23/2024, 11/24/2024, 11/25/2024, 11/28/2024, and 11/30/2024. This resulted in 12 different missed administrations. Further showed no documentation of MD notification of medication refusal.

Record review of MAR for R3 dated 11/01/2024-11/30/2024 showed Budesonide (A medication used to help control asthma) refused on 11/10/2024, 11/11/2024, 11/14/2024, 11/15/2024, 11/16/2024, 11/17/2024, 11/21/2024, 11/23/2024, 11/24/2024, 11/25/2024, 11/28/2024, and 11/30/2024. This resulted in 13 missed administrations. Further showed no documentation of MD notification of medication refusal.

Record review of progress notes for R3 dated 11/01/2024-12/01/2024 showed no documentation of MD notification of medication refusal.

In an interview on 12/12/2024 at 1130AM with Staff A, Medication Technician, stated that they must attempt three times before marking a medication down as refused and that if it is refused they must notify the manager, primary care provider, and put the resident on alert charting.

In an interview on 12/12/2024 at 223PM with Staff B, Executive Director, stated that if a resident refused a medication they would expect the medication technician to notify the primary care provider and the power of attorney.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 01.31.2025.

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

Administrator (or Representative) 12.31.24 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain medications in a timely manner for 3 of 5 (Resident 1, 2, & 3[R1, 2, &3]) sampled residents. This failure resulted in increased pain for Resident 3 from not receiving medications as prescribed, and placed all residents at risk for unmet care needs.

Findings included...

Record Review of facility policy titled "Ordering & Re-Ordering Medications", undated, stated "If a medication is not available in the community at the time needed, follow the procedure for 'medication not available.'"

Record review of facility policy titled "Medication not available", undated, stated "Alert the physician about unavailability and ask for an order to hold the medication until the

planned delivery". Further states "Notify the executive director and the community LN (Licensed Nurse) about the missed dose".

Record review of statement from Staff C, Medication Technician, dated 11/30/2024, stated "Every night that I work on the assisted living side, Resident 3 (R3) asks if she has a pain pill available because she is hurting. I have not given her any oxycodone (A medication for pain management) in the time frame of the missing meds."

Record review of Medication Administration Record (MAR) for R1 dated 11/01/2024-11/30/2024 showed "Medication not arrived" for Lanthanum Carbonate (a medication for kidney disease) for the dates of 11/01/2024, 11/02/2024, 11/03/2024, 11/04/2024, 11/05/2024, and 11/06/2024. This resulted in 18 missed doses.

Record review of MAR for R1 dated 12/01/2024-12/31/2024 showed "Medication not arrived" for Fosrenol (a medication for kidney disease) for the dates of 12/06/2024, 12/07/2024, 12/08/2024, 12/09/2024, and 12/10/2024. This resulted in 13 missed doses.

Record review of MAR for R1 dated 12/01/2024-12/31/2024 showed "Medication not arrived" for isosorbide (a medication to prevent chest pain) for the dates of 12/07/2024, 12/08/2024, 12/09/2024, and 12/10/2024. This resulted in four missed doses.

Record review of MAR for R2 dated 12/01/2024-12/31/2024 showed "Medication not arrived" for Eliquis (a medication to prevent blood clots) for the dates of 12/10/2024,12/11/2024, and 12/12/2024. This resulted in six missed doses.

Record review of MAR for R3 dated 11/01/2024-11/30/2024 showed "Medication not arrived" for oxycodone for the dates of 11/27/2024, 11/28/2024, 11/29/2024, and 11/30/2024. This resulted in four missed doses.

Record review of progress notes for R3 dated 11/22/2024 showed that Staff A, Medication Technician, notified Staff D, Health and Wellness director of the missing oxycodone.

Record review of progress notes for R3 dated 11/30/2024 showed that R3 was placed on alert charting to be "...monitored for withdrawal symptoms along with sign/symptoms of increased pain". Later documentation showed R3 stating "I ache everywhere but that's all the time".

In an interview on 12/12/2024 at 1130AM with Staff A, stated that they had notified Staff D of the lack of oxycodone for R3 on 11/22/2024.

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 01·31·25 by.

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

Administrator (or Representative) — Date: 12·31·24

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the Department of Social and Health Services (DSHS) Compliant Resolution Unit (CRU) upon notification of suspected sexual abuse for one of five (Resident 4) sampled residents. By not notifying CRU, the Department was unable to evaluate and ensure systems were in place to protect residents who may be at risk for potential abuse.

Findings included...

Record review of policy titled "Abuse, Neglect, or exploitation policy ADM 1-00 WA", undated, showed under the subheading of staff responsibilities "Any staff member who has a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation has occurred will notify the Department of Social and Health Services Complaint Resolution Unit (CRU) hotline at (866) 363-4276. The staff member should also report it immediately to someone within management so immediate interventions can take place."

Record review of Department of Social and Health Services (DSHS) internal Secure Tracking And Reporting System (STARS) showed no complaints sent to the CRU related to abuse of R4 between 10/01/2024-11/25/2024.

Record review of investigation of incident between Staff H and R4 was requested from Staff B. None was provided.

In an interview on 12/12/2024 at 146PM with R4, stated she told CC2 about the alleged abuse during a care conference in October and that CC1 was present during that care conference. Further stated "It makes me feel afraid, and not having any ability to change what's going to happen or not. I honestly feel like he's just waiting for a time. I'm really not trying to be emotional, silly woman about this, that's not it. I feel very vulnerable. Even when I went downstairs to get the Potassium and there he stood. Well after night shift. My heart starts racing, he's right here."

In an interview on 12/17/2024 at 1120AM with CC1, stated that during the care conference the concerns about Staff B came up. Further stated "CC2 stated to me, that she was going to share this information with Staff J, I reminded that she is a mandatory reporter"

In an interview on 12/12/2024 at 223PM with Staff B, Executive Director, stated that R4 made them aware of Staff H entering R4's room a couple of months ago, and that following the investigation it was determined to be unfounded.

In an interview on 12/12/2024 at 223PM with Staff B, when asked if the incident related to R4 and Staff H should have been reported to the state, stated "Absolutely. I don't know why it didn't."

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, PARK VISTA RETIREMENT& ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 01·31·25 .

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

Administrator (or Representative) 12·31·24 Date