STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

02/11/2025

SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Rd SE
SALEM, OR 97317

RE: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY # 1913

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 54078 (Completion Date 02/11/2025) and 49217 (Completion Date 12/06/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/11/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term

care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

The Department staff who did the On Site verification:

Cristina Gonzalez, ALF Licensor
Melissa Phillips, Long Term Care Surveyor

If you have any questions, please contact me at (360)651-6846.

Sincerely, Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 1913	Compliance Determination # 49217
Plan of Correction	SPRING CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 6	Licensee: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	12/06/2024

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 follow-up on 10/22/2024 and 12/06/2024 of:
SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
223 EAST BAKERVIEW ROAD
BELLINGHAM, WA 98226

This document references the following SOD dated: 12/06/2024

The following sample was selected for review during the unannounced on-site visit: 6 of 95 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Cristina Gonzalez, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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 enclosed report.

Kim Ripley
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)

12-30-2024
Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 3 staff (Staff B, C, and D) completed a Washington State Name and Date of Birth background check every two years. This failure resulted in Staff B, C, and D working with vulnerable adults while having unknown criminal backgrounds with potentially disqualifying crimes and placed all 95 residents at risk for harm.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 11/29/2023, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/24/2024.

Review of the ALF's employee files showed the following:

Staff B, Caregiver, was hired on 08/01/2020. No current background checks for Staff B were available for review.

Staff C, Cook, was hired on 09/12/2022. No current background checks for Staff C were available for review.

Staff D, Medication Technician, was hired on 08/25/2020. No current background checks for Staff D were available for review.

On 12/06/2024 at 12:37 PM, Staff A, Executive Director, stated that they did not have any current two-year background checks for Staff B, C, and D. Staff A stated that Staff B, C, and D should have had a new background check run this year.

This is an uncorrected citation previously cited on 11/29/2023.

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, SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 1-30-2025

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

Administrator (or Representative) — Date: 12-30-2024

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 5 of 5 staff (Staff E, F, G, H, and M) completed specialty dementia training. This failure resulted in Staff E, F, G, H, and M not having the training on how to effectively and safely provide care to residents living with dementia and placed all 28 residents with a [redacted] diagnosis at risk for compromised care and safety.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 11/29/2023, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/24/2024.

Review of the ALF's Resident Characteristic Roster, dated 12/06/2024, showed 28 residents who lived in the ALF had a diagnosis of [redacted].

Review of the ALF's employee files showed the following:

Staff E, Caregiver, was hired on 05/28/2024. There was no documentation that Staff E had completed dementia specialty training.

Staff F, Caregiver, was hired on 06/04/2024. There was no documentation that Staff F had completed dementia specialty training.

Staff G, Caregiver, was hired on 04/23/2024. There was no documentation that Staff G had completed dementia specialty training.

Staff H, Medication Technician, was hired on 05/28/2024. There was no documentation that Staff H had completed dementia specialty training.

Staff M, Caregiver, was hired on 08/05/2024. There was no documentation that Staff M had completed dementia specialty training.

On 12/06/2024 at 12:22 PM, Staff A, Executive Director, stated that Staff E, F, G, H, and M had not completed their dementia training. Staff A stated that the majority of care staff will be enrolled in their upcoming dementia specialty class to get back in compliance with the regulations.

On 12/06/2024 at 1:01 PM, Staff M stated that they hadn't taken any classes related to dementia specialty training yet.

This is an uncorrected citation previously cited on 11/29/2023.

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, SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 1.20.2025

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

S K Chambers — Administrator (or Representative)

12.30.2024 — Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 4 staff (Staff I, J, K, and L) completed 12-hours of continuing education (CE) per year. This failure resulted in Staff I, J, K, and L not having their continuing education training up-to-date and placed all 95 residents at risk for compromised care and safety.

Findings included...

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 11/29/2023, the Assisted Living Facility (ALF) received a citation for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 01/24/2024.

Review of the ALF's employee files showed the following:

Staff I, Medication Technician, was hired on 06/06/2022. There was no documentation that Staff I had completed any continuing education in the time period between their last two birthdays.

Staff J, Medication Technician, was hired on 11/19/2018. There was no documentation that Staff J had completed any continuing education in the time period between their last two birthdays.

Staff K, Caregiver, was hired on 07/25/2020. There was no documentation that Staff K had completed any continuing education in the time period between their last two birthdays.

Staff L, Caregiver, was hired on 08/16/2023. There was no documentation that Staff K had completed any continuing education in the time period between their last two birthdays.

On 12/06/2024 at 12:22 PM, Staff A, Executive Director, stated that Staff I, J, K, and L had not completed any continuing education hours. Staff A stated that they weren't really managing it and had just recently enrolled all care staff into their CE program.

On 12/06/2024 at 12:51 PM, Staff J stated that Staff A had just signed them up for a CE program and they would be working on completing the classes on there.

This is an uncorrected citation previously cited on 11/29/2023.

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, SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) 1.20.2025.

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

Administrator (or Representative) — Date: 12.30.2024

Residential Care Services
Investigation Summary Report

Provider/Facility: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1913
Compliance Determination #: 32134
Investigator: Cristina Gonzalez
Investigation Date(s): 11/06/2023 through 11/29/2023
Complainant Contact Date(s): 11/07/2023

Provider Type: Assisted Living Facility

Intake ID: 104983
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):

1) The Named Resident (NR) had inflammation of the mouth, was prescribed chlorhexadine liquid which was provided to nursing staff and the medication was not given for four days and was still in the medication cart.
2) The NR has Alzheimer's Dementia, there is no follow-up on her mouth or medications.
3) It took over a week for the NR's medications to get distributed when the NR went on medication services and the NR did not receive tylenol or nystatin and was in pain.

Investigation Methods:

Sample:	Total residents: 91 Resident sample size: 9 Closed records sample size:
Observations:	NR and NR's living quarters, staff response to resident care needs, medication carts and medications, electronic medication administration system
Interviews:	Executive Director, Registered Nurses, Named Resident, Family Med Technicians
Record Reviews:	NR's medical records including negotiated service agreement and assessments, physician medication orders and notifications, electronic medication administration records for October and November 2023, progress notes, self-medication evaluation, pharmacy agreement, family plan with medication, Naturopathic Physician orders, Dental oral prescriptions, after visit summary

Investigation Summary:

1) The NR was assessed to have complaints of dry mouth. A Physician visit on 11/01/2023 showed the NR was seen for oral pain. The NR's continued medications included Chlorhexidine 0.12% solution to swish and spit out twice a day. Progress notes dated 11/06/2023 showed attempts to clarify Chlorhexidine orders that were written on 10/21/2023. No Chlorhexidine orders were on the NR's electronic

medication administration record. No doses of Chlorhexidine were provided to the NR. Failed practice identified. A citation was issued for noncompliance with WAC 388-78A-2210 (1)(b) Medication services.
2) The NR's electronic medication administration records (EMARs) were reviewed for October and November 2023. The NR's EMARs showed multiple medication refusals by the NR. No documentation was available for review when requested to show the Physician was notified. Failed practice identified. A citation was issued for noncompliance with WAC 388-78A-2230 (1)(c)(ii) Medication refusal.
3) The NR's EMARs for October and November 2023 were reviewed. The EMARs showed multiple medications were not available including a pain medication. The NR's Physician was notified the ALF was now managing medication for the NR. The form was dated initially 09/30/2023, that date was crossed out then written 10/04/2023. Medication orders dated 10/01/2023 were not provided until 10/05/2023. Failed practice identified. A citation was issued for noncompliance with WAC 388-78A-2240 Non-availability of medications.

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
3906-172nd St NE, Suite #100, Arlington, WA 98223

12/13/2023

Licensee: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Rd SE
SALEM, OR 97317

RE: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1913

Dear Administrator:

The Department completed a full inspection and a complaint investigation of your Assisted Living Facility on 11/29/2023 and found that your facility does not meet the Assisted Living Facility licensing requirements.

The Department:

- Wrote the enclosed Statement of Deficiencies (SOD) report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Kimberley Ripley, Field Manager
Residential Care Services
Region 2, Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

You May:

• Receive a letter of enforcement action based on any deficiency listed on the enclosed report.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (360)651-6846.

Sincerely, Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Enclosure

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 the unannounced on-site full inspection and complaint investigation on 11/06/2023, 11/07/2023, 11/08/2023 and 11/14/2023 of:

SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
223 EAST BAKERVIEW ROAD
BELLINGHAM, WA 98226

This document references the following complaint numbers: 104862, 104846, 104145, 104983.

The following sample was selected for review during the unannounced on-site visit: 9 of 91 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Judith Mellon, RN, Licensor
Cristina Gonzalez, ALF Licensor
Judith Mellon, RN, Licensor
Allison Nunn, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley

Residential Care Services

12/13/2023

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.

Administrator (or Representative) Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations and interviews, the Assisted Living Facility (ALF) failed to keep 2 of 4 floors (first floor and second floor) safe and sanitary. These failures resulted in all 91 residents living in an unsafe and unsanitary environment and placed all residents at risk for injury and a decreased quality of life.

Findings included…

The ALF consisted of four floors with a secured memory care unit located on the first floor. The following observations were made on 11/06/2023.

First floor:

At 10:14 AM, the cupboard under the salad bar in the dining room had a pipe that was dripping. There was a black circular spot 4-inches by 3-inches underneath the leaking pipe.

On 11/06/2023 at 10:14 AM, Staff B, Maintenance Director, stated that he wasn't aware of the leaking pipe, and he would fix it right away.

At 10:15 AM, the door to the kitchen had black scrapes and worn paint exposing the metal underneath. The top of the kitchen door had a metal bar that rubbed the door when it opened and closed.

At 10:16 AM, there were brown spots inside the cupboards in the dining room.

At 10:17 AM, the exit door from the dining room had surface abrasions exposing the metal underneath.

At 10:19 AM, a handwashing sink by the ice machine in the kitchen had a grape stem and leaves in the drain showing the sink had been used for something other than handwashing.

At 10:21 AM, the door to the dry storage in the kitchen had dried brown liquid on the surface.

At 10:25 AM, a handwashing sink by the dish washing area had food debris around the edges.

At 10:25 AM, the red sanitizer bucket in the dish washing area had no water and contained a piece of steel wool and a white sugar packet.

At 10:33 AM, the cupboard in the medication room had crumbs and a dried circular brown spot that was 2-inches by 2-inches.

At 10:34 AM, the vent above the housekeeping closet had a buildup of dust.

At 10:35 AM, there was a buildup of dust and lint on the floor around the washing machine in the laundry room. Dirty rags were piled on top of a 5-gallon bucket next to the washer.

On 11/06/2023 at 10:36 AM, Staff B stated that the 5-gallon bucket was liquid laundry detergent. Staff A, Executive Director, stated that the rags should not be on top of the bucket.

At 10:36 AM, there were white tissues and plastic bags laying on the floor in front of the dryer.

At 10:38 AM, there were open packages of unused adult disposable briefs on the shelf in the housekeeping closet.

At 10:40 AM, a brown box that contained an unidentified dry powder was not closed.

On 11/06/2023 at 10:40 AM, Staff B stated that the brown box was a powder laundry detergent used to wash resident clothing. Staff A stated that the box should be closed.

At 10:42 AM, there was dust and cobwebs in the supply closet next to the memory care entrance.

At 10:44 AM, a drawer in the resident laundry room had an oxygen supply cord and a cup of unidentified white powder.

At 10:44 AM, the washing machine had a buildup of dust and debris under the lid.

At 10:46 AM, the ceiling vent near apartment 117 had a buildup of dust.

At 10:47 AM, the door to apartment 119 had surface abrasions exposing the metal underneath.

At 10:47 AM, the door to apartment 122 had surface abrasions exposing the metal underneath. The metal door frame was dented at the bottom.

At 10:53 AM, the ceiling vent in the bathroom had a buildup of dust.

At 10:56 AM, the tile above the communication closet had a missing corner exposing the space above the ceiling.

At 11:01 AM, the light above apartment 141 was missing a cover.

On 11/06/2023 at 11:01 AM, Staff B stated that he bought a new plastic cover, but it was too big. He tried to cut the plastic to fit but it broke. Staff B stated that he was waiting for a call back from a vendor to get the right sized light cover.

At 11:12 AM, there were no paper towels next to the handwashing sink in the memory care activity room.

At 11:12 AM, the sink in the memory care activity room had an empty soap dispenser. The handle to dispense the soap was missing.

At 11:15 AM, the door to the medication room had surface abrasions exposing the metal underneath.

Second floor:

At 11:25 AM, there was a 0.5-inch hole in the wall above the baseboard at the top of the stairwell.

At 11:28 AM, the resident laundry room had a buildup of dust behind the dryers. There was a piece of paper, two washcloths and an undergarment behind the dryer.

At 11:29 AM, the light cover at the entrance to the resident laundry room was missing.

At 11:41 AM, the “Roof top equipment” door in the resident library was unlocked.

On 11/06/2023 at 11:42 AM, Staff B stated that the door should not be unlocked.

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, SPRING CREEK 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

WAC 246-215-03351 Preventing contamination from the premises Food storage (FDA Food Code 3-305.11).

(1) Except as specified in subsections (2) and (3) of this section, food must be protected from contamination by storing the food:

(b) Where it is not exposed to splash, dust, or other contamination; and

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to cover food items to prevent contamination when 2 of 3 food storage locations (walk-in refrigerator and dry food pantry) had uncovered food items. This failure resulted in food items being exposed to dust particles in the air and placed all 91 residents at risk for a food borne illness.

Findings included…

A tour of the ALF's kitchen on 11/06/2023 at 10:22 AM. The following observations were made:

The dry food pantry in the kitchen had an uncovered baked apple crisp in a pan sitting on the shelf. A bag of Rice Krispies cereal was open and laying on the shelf in the dry food pantry.

The walk-in refrigerator in the kitchen had apple crisp that was uncovered and dished into individual plastic containers.

On 11/06/2023 at 10:26 AM, Staff A, Executive Director, stated that the apple crisp should not be stored in the dry food pantry. Staff A stated that the apple crisp would be thrown away and not served to the residents.

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, SPRING CREEK 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

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to ensure potentially harmful items were safely stored away from 2 of 2 memory care residents (Resident 3 and 4) on the secured memory care unit. This failure resulted in several high-risk items being accessible to all 16 memory care residents and placed these residents at

risk of harm from exposure to hazardous materials.

Findings included…

Resident 3
Resident 3 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Resident 4
Resident 4 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

The ALF contained a memory care unit, a secured section of the facility that provided care and services for residents with various stages and types of dementia (the loss of cognitive functioning — thinking, remembering, and reasoning — to such an extent that it interferes with a person's daily life and activities).

On 11/06/2023 at 11:04 AM, the ALF's memory care unit activity room was observed to have an unlocked cabinet that had the following items accessible to residents with dementia: a plastic zipper pouch with sewing needles, safety pins, a curling iron, an open can of Red Bull drink partially empty, one bottle of stress relief cream and one can of hairspray.

On 11/06/2023 at 11:05 AM, three two-door storage cabinets with bar pull handles on each door were observed with cable locks that looped around the door handles. The length of the cable locks allowed the cabinet doors to be partially opened, allowing the following items to be accessed: several bottles of nail polish, one 2.8-ounce bingo dotter, and two 8-ounce bottles of 100% acetone nail polish remover. The label on the nail polish removers read "Irritating to eyes and mucus membranes... Harmful if inhaled or ingested. In case of accidental ingestion, consult a doctor immediately."

On 11/06/2023 at 11:09 AM, a second unlocked cabinet was observed to have the following: a plastic pitcher labeled "Sterilized for Fish Tank" that held one 16-ounce bottle of Algaefix, one 16-ounce bottle of Aqueon Water Conditioner, one 8.5-ounce bottle of "Stability" and one 3.38 fluid ounce of Tetra Aquasafe. A warning label showed harmful if swallowed or absorbed through the skin.

In an interview on 11/06/2023 at 11:13 AM, Staff B, Maintenance Director, stated that the keys to lock the memory care cabinets were lost and that there were new locks for the cabinets. Staff B stated that the locks would be addressed.

In an interview on 11/06/2023 at 11:14 AM, Staff A, Executive Director, stated that the cabinets were to be locked on a memory care unit to prevent the memory care residents from obtaining the items and removed the items immediately.

Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

WAC 246-215-03526 Temperature and time control Ready-to-eat, time/temperature control for safety food, date marking (FDA Food Code 3-501.17).

(4) A date marking system that meets the criteria stated in subsections (1) and (2) of this section may include:

(a) Using a method approved by the regulatory authority for refrigerated, ready-to-eat, time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft-serve mix or milk in a dispensing machine;

(b) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (1) of this section;

(c) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under subsection (2) of this section; or

(d) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request.

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation and interview, the Assisted Living Facility (ALF) failed to remove expired food from 1 of 1 memory care kitchenettes. This failure resulted in expired food being readily available to serve to residents and placed all 16 memory care residents at risk

for a food borne illness.

Findings included…

During a tour of the ALF on 11/06/2023 at 11:12 AM, a jar of peanut butter with an expiration date of July 2023 was observed in the memory care kitchenette cupboard. A loaf of raisin bread with an expiration date of October 2023 was placed next to the peanut butter on the shelf. There was an opened package of round grain crackers with no expiration date laying on the shelf.

In an interview on 11/06/2023 at 11:20 AM, Staff B, Maintenance Director, stated that the items should not be in the cupboard if they are expired. Staff B threw away the items immediately.

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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-2250 :

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to implement a safe medication service system for 3 of 3 residents (Resident 2, 7, and 9). The failure resulted in Residents 2, 7, and 9 not receiving medications as prescribed and residents 2 and 7 having inaccurate medication administration records (MAR). This failure resulted in the Residents not receiving their prescribed medications, failed to provide correct instructions for staff, and placed the residents at risk for medical complications.

Findings included…

Resident 2

Resident 2 was admitted into the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted].

Review of Resident 2's most recent negotiated service agreement (NSA) dated 10/02/2023 showed that Resident 2 was to receive support from the ALF with medication administration.

In an interview on 11/07/2023 at 1:40 PM, Collateral Contact 1 (CC1), stated that Resident 2 was having complaints of mouth pain and Staff C, Registered Nurse saw Resident 2 and stated that Resident 2's mouth looked inflamed and suggested a visit to a walk-in clinic. CC1 stated that they saw the Physician and had left the medication Chlorhexidine with a signed order with a Med Tech at the ALF. CC1 stated that a couple days later the same Med Tech opened the medication cart drawer and Resident 2's Chlorhexidine was still in the drawer. The medication had not been given to Resident 2.

In an interview on 11/14/2023 at 8:46 AM, Staff C, Registered Nurse stated that the Physician thought Resident 2 had thrush (a fungal infection of the mouth). Staff C stated that they believed a Med Tech faxed a request for a Physician's order because they heard the order wasn't signed. Staff C stated that they didn't think the Physician responded.

Review of Resident 2's After Visit Summary dated 11/01/2023 at 2:00 PM, showed Resident 2 saw the Physician for Oral Pain and addressed dry nostrils. Resident 2 was to start Sodium Chloride 0.65% nasal spray (a treatment for dryness inside the nose) every five minutes as needed, and was to continue taking current medications which included Chlorhexidine 0.12% solution, swish and spit out 15 mL's (unit of measurement) twice a day.

Review of Resident 2's Electronic Medication Administration Records (EMARs) for the month of October and November 2023 showed that Chlorhexidine was not on the EMAR. The November 2023 EMAR showed that the Sodium Chloride 0.65% nasal spray was entered into the EMAR on 11/06/2023 at 9:31 PM, five days later after the Physician visit.

Review of Resident 2's chart notes showed the following:
1) Dated 10/29/2023 at 4:14 PM, Staff C documented speaking with family about thrush, Resident 2 refusing nystatin pills and that the nystatin pills were not effective for thrush and had recommended a clinic visit to seek assistance for thrush since it was bothersome to Resident 2.
2) Dated 11/06/2023 at 4:15 PM, showed Staff J, Registered Nurse documented: attempted to call to clarify orders for Chlorhexidine Solution written on 10/21/2023 after visit to urgent care provider.
3) Dated 11/07/2023 at 11:41 AM, Staff J documented that she called the Physician's office about Chlorhexidine swish orders and to clarify whether the Chlorhexidine medication should start or stop.

In an interview on 11/14/2023 at 8:25 AM, Staff I stated that Resident 2's family had brought in Chlorhexidine and staff thought it wasn't a valid order because they didn't see a signature. Staff I stated that she faxed the Physician and thought they had discontinued the Chlorhexidine but wasn't sure. Staff I stated that Resident 2 was not taking the Chlorhexidine and that it was not in her orders on the EMAR when she was passing medications.

Review of Resident 2's oral prescriptions from an outside dental provider dated 11/02/2023 showed the Chlorhexidine, ordered by the physician, was to be discontinued. The dentist had signed the order. Multiple dates were on the dental orders, signed by nursing staff on 11/02/2023, 11/04/2023 and 11/06/2023 to indicate the dental orders were reviewed and faxed to the pharmacy. No documentation was available to show Chlorhexidine was provided to Resident 2 as prescribed by the Physician.

Resident 7

Resident 7 was admitted into the ALF on [redacted]/2023 with multiple medical diagnoses including [redacted].

Review of Resident 7's NSA dated 08/06/2023 showed the ALF would provide support with medication administration, staff would store, order and dispense medications as ordered by the Physician and had a urinary catheter requiring staff support. The NSA showed Resident 7 was independent with cognitive needs and able to communicate needs.

Record review of a self-administration medication evaluation dated 08/27/2023 showed Resident 7 had a Physician order to self-administer part of their medications/treatments dated 07/06/2023. Resident 7 was to manage Estradiol 0.01% cream (a hormone used to reduce vaginal symptoms of menopause such as dryness/burning/itching) application vaginally two days weekly.

Record review of Resident 7's electronic medication administration records (EMARs) for September, October and November 2023 showed Estradiol was to be applied twice weekly

on Sundays and Wednesdays. The order start date was 07/26/2022. The EMARs showed no information that Resident 7 had self-administered the Estradiol.

In an interview on 11/14/2023 at 8:46 AM, Staff C, Registered Nurse stated that Resident 7 self-administered Estradiol 0.01% cream to be applied vaginally two days weekly. Staff C stated that there was no system to track residents that self-medicate. Staff C stated that there is no way to know if a resident takes their medication and that the nursing staff do not document on the EMAR. Staff C stated they wouldn't know if the residents took their medication or not, and maybe it would be a good idea to go and check on these people once a week to make sure it's done.

In an interview on 11/14/2023 at 11:02 AM, Resident 7 stated that the ALF brings their medications for Resident 7 to take. The staff stopped bringing the Estradiol a long time ago. Resident 7 stated they haven't used it since they got a catheter a year or two ago.

An observation on 11/14/2023 at 3:33 PM, in Resident 7's medicine cabinet in the bathroom a discolored tube of Estradiol cream was observed to have a label that showed a fill date of 11/09/2022 with no other dates.

No documentation was observed on Resident 7's medical record to show that the Estradiol cream was discontinued.

Resident 9

Resident 9 was admitted to the ALF on [redacted]/2020 with multiple medical diagnoses including [redacted].

Review of the NSA dated 09/06/2023 showed Resident 9 required medication administration support from the ALF. The NSA showed staff were to store, order, and deliver Resident 9's medications per physician orders.

Review of Resident 9's EMAR dated 11/07/2023 showed Metoprolol (a medication that lowers blood pressure, making it easier for the heart to pump blood to the rest of the body decreasing the likelihood of heart damage) was to be given one time a day for hypertension beginning on 10/11/2023. Resident 9's EMAR for the month of October 2023 showed Metoprolol was marked as not available from 10/11/2023 to 10/17/2023. Documentation entries on the EMAR for Resident 9's Metoprolol showed the following entries "waiting for medication to arrive", "waiting for order", "new med – not here yet".

In an interview on 11/14/2023 at 11:30 AM, Staff C stated that ALF staff don't have anything they can do about getting medications sooner than when the pharmacy mails the

prescription, and it arrives at the ALF. Staff C stated that ideally, they would obtain a same-day short-term supply of the medication from a local pharmacy and give it to the resident before the order arrives in the mail.

In an interview on 11/14/2023 at 3:20 PM, Staff L, Regional Director of Operations, stated that the ALF was responsible for obtaining and providing medications to the residents who require medication services. Staff L stated that staff need to obtain either a short order supply of a medication while pending pharmacy arrival, work with the resident's medical provider, or ask the physician to hold the medication until it arrives to the ALF. Staff L stated that they will work on staff education on medications from mail-order pharmacies.

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Administrator (or Representative) Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 6 staff (Staff G and H) had a background check every two years. This failure resulted in Staff G and Staff H not having an updated background check and placed the safety of all 91 residents at risk of being cared for by a staff person with a disqualifying background.

Findings included…

Review of the ALF's employee files showed the following:

Staff G, Medication Technician, was hired on 06/28/2018. Staff G's background check was dated 12/08/2020 with an expiration date of 12/08/2022.

Staff H, Caregiver, was hired on 08/24/2021. Staff H's background check was dated 09/21/2021 with an expiration date of 09/21/2023.

In an interview on 11/08/2023 at 10:05 AM, Staff K, Assistant Executive Director, stated that both these background checks must have been missed during their review.

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Administrator (or Representative) Date

WAC 388-112A-0400 What is specialty training and who is required to take it?

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(b) Dementia specialty training as described in WAC 388-112A-0440 ;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 staff (Staff D, E, and F) completed specialized dementia training. This failure resulted in Staff D, E, an F not being trained to provide care to residents with dementia and placed all residents with a diagnosis of [redacted] at risk of not receiving proper care.

Findings included…

Review of the ALF's Resident Characteristic Roster dated 11/06/2023, showed 25 residents living in the ALF had a diagnosis of [redacted].

Review of the ALF's employee files showed the following:

Staff D, Medication Technician, was hired on 07/22/2022. No documentation of specialized dementia training was found in Staff D's file.

On 11/07/2023 at 2:34 PM, Staff K, Assistant Executive Director, stated that it didn't appear that Staff D had completed their dementia training.

Staff E, Caregiver, was hired on 01/17/2023. No documentation of specialized dementia training was found in Staff E's file.

Staff F, Caregiver, was hired on 01/17/2023. No documentation of specialized dementia training was found in Staff F's file.

In an interview on 11/07/2023 at 2:42 PM, Staff K, Assistant Executive Director, stated that Staff E and F were hired on the same day. Staff K stated that to their knowledge, the ALF had not offered a dementia specialty training class since their date of hire, but that they were working on updating that as soon as possible.

In an interview on 11/08/2023 at 3:35 PM, Staff E stated that they had taken the mental health specialty class when they were first hired at the ALF. Staff E stated that this class also discussed dementia to some degree, but that their certification showed only a mental health class was completed.

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Administrator (or Representative) Date

WAC 388-112A-0611 Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?

(1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below.

(a) The following long-term care workers must complete twelve hours of continuing education by their birthday each year:

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(e) Continuing education.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 4 of 6 staff (Staff D, E, G, and H) completed twelve hours of continuing education (CE) per year. This failure resulted in Staff D, E, G, and H not having 12 hours of CE and placed all 91 residents at risk of being cared for by staff who were not up to date in best practices and improved resident care.

Findings included…

Review of the ALF's employee files showed:

Staff D, Medication Aide, with a birthdate (BD) of November 12, completed 0 of 12 CE hours.

Staff E, Caregiver, with a BD of January 1, completed 0 of 12 CE hours.

Staff G, Medication Aide, with a BD of June 19, completed 0 of 12 CE hours.

Staff H, Caregiver, with BD of August 7, completed 0 of 12 CE hours.

In an interview on 11/07/2023 at 2:37 PM, Staff K, Assistant Executive Director, stated that the manager will ensure the staff members completed the CE training. Staff K stated that the staff CE training is not up to date.

In an interview on 11/08/2023 at 10:07 AM, Staff K, Assistant Executive Director, stated that the program they use for CE training does not have any classes assigned to the staff members.

In an interview on 11/08/2023 at 10:57 AM, Staff A, Executive Director, stated that there was not any tracking to ensure CE's were completed.

In an interview on 11/08/2023 at 3:35 PM, Staff E, Caregiver, stated that she has had trouble accessing the training program. Staff E stated that she hasn't completed any of the CE training.

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Administrator (or Representative) Date

WAC 388-112A-0720 What are the CPR and first-aid training requirements?

(2) Assisted living facilities.

(a) Assisted living facility administrators who provide direct care and long-term care workers must have and maintain a valid CPR and first-aid card or certificate within thirty days of their date of hire.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 6 staff (Staff E) completed First Aid and Cardiopulmonary Resuscitation (CPR) training. This failure resulted in Staff E not being trained in First Aid/CPR and placed all 91 residents at risk for harm due to Staff E not being certified to provide CPR and basic first aid skills.

Findings included…

Review of the ALF's employee files showed that Staff E, Caregiver, was hired on 01/17/2023. No documentation of First Aid/CPR certification was found in Staff E's file.

In an interview on 11/07/2023 at 2:42 PM, Staff K, Assistant Executive Director, stated that they could not find documentation of current First Aid/CPR training for Staff E.

In an interview on 11/08/2023 at 3:35 PM, Staff E stated that they are not currently First Aid/CPR certified.

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