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

02/18/2025

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) 54290 (Completion Date 02/18/2025) and 49760 (Completion Date 12/24/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/18/2025 and found no deficiencies.

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

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

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.

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

The Department staff who did the On Site verification:
Helen Fisher, Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1913
Compliance Determination #: 49760
Investigator: Helen Fisher
Provider Type: Assisted Living Facility
Intake ID: 152408
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 11/05/2024 through 12/24/2024
Complainant Contact Date(s): 11/05/2024

Allegation(s):
The Assisted Living Facility (ALF) was:
1) inadequately implementing medical orders.
2) not consistently arranging outpatient appointments for the NR. The NR had missed multiple wound appointments.
3) unable to provide the increase level of care the NR needed.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 4 Closed records sample size:
Observations:	NR's appearance and demeanor, living quarter, equipment used.
Interviews:	NR, Collateral contact, registered nurse (RN), med tech, caregiver, Regional Director of Operation (RDO).
Record Reviews:	NR's negotiated service agreement, progress notes, incident report, medication administration records.

Investigation Summary:
1) Interviews indicated that the NR's blood test to measures the blood clotting time (INR) had been taken inconsistently by the ALF, in which resulted in dosing inaccuracy of the blood thinner medications. The RN stated that the INR testing was at first done by the outside agency but eventually was turned over to them. The RN stated that there were times the test strip used for INR testing had run out therefore the testing did not get done on time. The RN stated that the med tech may have been giving or not giving the blood thinner dosage due to the delay in testing. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2210 Medication services.
2) The NR stated that they missed three of their wound care appointments because staff was not paying attention to call and arrange transportation for them. The NR missed five wound care clinic appointments in two months which resulted in cancellation of appointments by the Wound Care Clinic due to no show. The RN

stated that there were times the NR refused to go and other time the transportation was not set up by staff. Failed practice identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2350 Coordination of health care services.
3) The NR stated that they needed two staff assistance with transfers, showers, dressing and toileting needs. The NR stated that there were times they refused to shower because it was too hard for them to get in and out of the shower. Review of the negotiated service agreement showed the NR required 2-person assistance with transfers using a lift equipment, showers, toileting and dressing. The NR stated that the staff had been providing the care assistance and had no issues. However, the NR stated that the housekeeping staff vacuumed the carpeting but not shampooed as they can remember. The NR's bed had two blue used disposable pads, two pillows had no pillowcases exposing the yellowish stains, a twelve-by-twelve piece of drywall patched on the wall was bent, paper debris and a plastic straw on the floor, multiple black and dark brown stains on the carpeting, and the carpeting seam between the living room and bedroom was ripped creating a trip hazard. The RDO stated they had a plan to move the NR to another apartment so the NR's current apartment could be repaired. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-3090 Maintenance and Housekeeping.

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: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1913
Compliance Determination #: 49760
Investigator: Helen Fisher
Investigation Date(s): 11/05/2024 through 12/24/2024
Complainant Contact Date(s): 11/05/2024

Provider Type: Assisted Living Facility

Intake ID: 153162
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
1) The Named Resident (NR) had been neglected by the Assisted Living Facility (ALF).
2) The Assisted Living Facility (ALF) was short staffed.
3) The Named Resident (NR) urine test was not done in a timely manner.
4) The ALF's residents did not receive the medications as prescribed by the physician.

Investigation Methods:

Sample:	Total residents: 96 Resident sample size: 4 Closed records sample size:
Observations:	NR's appearance, living quarter, environment.
Interviews:	NR, Collateral contact 1 (CC1), med tech, regional director of operations (RDO), caregiver, memory care director (MCD), registered nurse, Collateral contact 2 (CC2).
Record Reviews:	NR's negotiated service agreement, progress notes, incident report, medication administration records.

Investigation Summary:
1) The NR was groomed with pleasant demeanor and their living quarter was clean and organized during an unannounced onsite visit at the ALF. The NR stated that the staff had been responsive when they needed something. Review of the NR negotiated service agreement showed the NR was able to use the call system and was independent with activities of daily living aside from medication assistance. Review of five resident's call responses showed response time one to eleven minutes. No failed practice was identified.
2) Three med techs, five caregivers, 2 housekeeping staff were working at the ALF during an unannounced onsite visit at the ALF. Interviews indicated that the ALF had been utilizing agency staffing to assist their short staffing problem. The Regional Director of Operations (RDO) stated that they have been in constant search via advertisement and outreach for qualified staff candidates. They have

support staff who filled in for call outs. Management staff were covering shifts also. The staff stated that they were fully staffed on caregivers and the agency was filling for med techs shortage. Five residents stated that the staff responded to their calls quickly. Review of the October staffing schedule showed the ALF utilizing agency to cover shifts. No failed practice was identified.
3) Interviews indicated that the NR's urine sample was collected within 3 days from the time it was ordered by the doctor on 10/24/2024. The CC2 stated that once it was brought up to the nurse attention the urine was collected and sent out to the laboratory right away. The NR urine sample was tested negative for bladder infection. No failed practice was identified.
4) The NR did not receive all their medications. Two sampled residents were found having medications discrepancies. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2210 Medication services.

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

Statement of Deficiencies	License #: 1913	Compliance Determination # 49760
Plan of Correction	SPRING CREEK RETIREMENT & ASSISTED LIVING	Completion Date
Page 1 of 8	Licensee: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC	12/24/2024

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 11/05/2024 and 11/05/2024 of:

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

This document references the following complaint number(s): 152352, 152408, 153162, 154387

The following sample was selected for review during the unannounced on-site visit: 4 of 96 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

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 — 01/06/2025

Residential Care Services — 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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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The department completed data collection for an unannounced on-site complaint investigation on 11/05/2024 and 11/05/2024 of:

SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
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The department staff that investigated the Assisted Living Facility:

Helen Fisher, Complaint Investigator

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.

Residential Care Services

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-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews, the Assisted Living Facility (ALF) failed to coordinate with the health care provider when 1 of 3 residents (Resident 1) had wound care clinic appointments. This failure resulted in Resident 1 missing 5 wound care appointments in 2 months, the wound care clinic cancelled Resident 1's upcoming appointments, and placed Resident 1 at risk for medical complications.

Findings included...

Resident 1

Resident 1 was admitted to the ALF on [redacted] /2021 with multiple diagnoses [redacted] and [redacted].

Review of the Resident 1's recent negotiated service plan dated 07/11/2024 showed Resident 1 was to receive ALF's assistance to arrange any necessary appointments and schedule bus transportation.

On 11/05/2024 at 3:05 PM, Resident 1's left leg wound was observed wrapped with a bandage.

Interview on 11/04/2024 at 11:35 AM, Collateral Contact 1 (CC1) stated that Resident 1 had a leg wound and had missed multiple appointments due to the facility's failure to follow through in arranging transportation and getting Resident 1 prepared to leave the ALF. CC1 stated that there was a greater chance Resident 1 was in jeopardy of being fired from the outpatient wound care clinic due to not showing up.

Administrator (or Representative) Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interviews, and record reviews, the Assisted Living Facility (ALF) failed to coordinate with the health care provider when 1 of 3 residents (Resident 1) had wound care clinic appointments. This failure resulted in Resident 1 missing 5 wound care appointments in 2 months, the wound care clinic cancelled Resident 1's upcoming appointments, and placed Resident 1 at risk for medical complications.

Findings included…

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2021 with multiple diagnoses [redacted] and [redacted].

Review of the Resident 1's recent negotiated service plan dated 07/11/2024 showed Resident 1 was to receive ALF's assistance to arrange any necessary appointments and schedule bus transportation.

On 11/05/2024 at 3:05 PM, Resident 1's left leg wound was observed wrapped with a bandage.

Interview on 11/04/2024 at 11:35 AM, Collateral Contact 1 (CC1) stated that Resident 1 had a leg wound and had missed multiple appointments due to the facility's failure to follow through in arranging transportation and getting Resident 1 prepared to leave the ALF. CC1 stated that there was a greater chance Resident 1 was in jeopardy of being fired from the outpatient wound care clinic due to not showing up.

In an interview on 11/05/2024 at 3:05 PM, Resident 1 stated that they missed their wound care clinic appointments because the ALF did not make their transportation appointments three times as they recalled. Resident 1 was unable to recall the dates.

In an interview on 11/05/2024 at 1:34, Staff A, Med Tech, stated that Resident 1 missed their wound care clinic appointments because the transportation was not set up. Staff A stated that the nurse was supposed to schedule Resident 1's rides.

In an interview on 11/27/2024 at 12:39 PM, Collateral Contact 2 (CC2), office staff stated that Resident 1 missed 5 appointments in August and September. CC2 stated that the ALF did not notify the wound care clinic when Resident 1 could not make it to their appointments. Because of the lack of notification and no shows from the ALF the wound care clinic had cancelled Resident 1's appointments for October.

In an interview on 11/27/2024 at 10:24 AM, Staff B, Registered Nurse, stated that they and the med techs were scheduling Resident 1's transportation for appointments. Staff B stated that there were times Resident 1 refused to go or the transportation did not show. Staff B stated that the Assisted Living Director took over the transportation scheduling in November.

Review of Resident 1's records showed no cancellation notifications to the wound care clinic were made by the ALF.

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) 02/01/2025 .

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

Lea Wortts Assistant ED — Administrator (or Representative)

1.24.25 — 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.

This requirement was not met as evidenced by:

In an interview on 11/05/2024 at 3:05 PM, Resident 1 stated that they missed their wound care clinic appointments because the ALF did not make their transportation appointments three times as they recalled. Resident 1 was unable to recall the dates.

In an interview on 11/05/2024 at 1:34, Staff A, Med Tech, stated that Resident 1 missed their wound care clinic appointments because the transportation was not set up. Staff A stated that the nurse was supposed to schedule Resident 1's rides.

In an interview on 11/27/2024 at 12:39 PM, Collateral Contact 2 (CC2), office staff stated that Resident 1 missed 5 appointments in August and September. CC2 stated that the ALF did not notify the wound care clinic when Resident 1 could not make it to their appointments. Because of the lack of notification and no shows from the ALF the wound care clinic had cancelled Resident 1's appointments for October.

In an interview on 11/27/2024 at 10:24 AM, Staff B, Registered Nurse, stated that they and the med techs were scheduling Resident 1's transportation for appointments. Staff B stated that there were times Resident 1 refused to go or the transportation did not show. Staff B stated that the Assisted Living Director took over the transportation scheduling in November.

Review of Resident 1's records showed no cancellation notifications to the wound care clinic were made by the ALF.

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-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.

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 1, 2, and 3). These failures resulted in Resident 1 having inconsistent clotting blood testing, receiving the discontinued blood thinner medication, and 7 medications were documented as "charted for the next shift"; Resident 2 and 3 not receiving medications as prescribed by the physician and placed the residents at risk for medical complications.

Findings included…

Review of the ALF's policy titled "Medication Assistance" dated 05-01-2023 showed:
The Community shall establish and maintain a safe, effective 24-hour medication delivery system for staff to administer, provide assistance for administration of, or allow residents to self-administer prescription and nonprescription (over the counter) medication/treatment, as allowed by state and pharmacy regulations. Do not re-label medication. A "Change of Order" sticker can be used to indicate order updates when it is appropriate to use the existing supply of medication while waiting delivery of new supply. Establish supply/order systems to make resident medications available when needed and document and notify when medication is unavailable. Be timely to provide medication administration/assistance according to physician orders, appropriately document all medication assistance/administration of medication. Advise the resident and family/representative about the Community requirements for medication packaging (i.e., bubble pact, etc.), prior to any move into the Community. According to the regulations that apply, appropriately train staff Med Tech/Quality Medication Administration Training (QMAP) to prepare and assist administration of medications. As needed, instruct health services staff and advise the Community's contracted pharmacy or other medication suppliers about medication system requirements. When the Community is responsible (per orders) for a resident's medication administration/assistance, new orders must be obtained and provided to whomever will be responsible during a leave of absence or after a move-out. Establish procedures for ordering and receiving medications into the Community and provide adequate instruction about the requirements for special tracking of narcotics and other controlled substances, including shift count verifications.

Resident 1

Resident 1 was admitted into the Assisted Living Facility (ALF) on [redacted]/2021 with multiple diagnoses [redacted] and [redacted].

A negotiated service agreement dated 07/11/2024 showed Resident 1 was to receive medication administration.

The physician's order dated 10/1/2024 to 10/30/2024 showed:
Stop Warfarin 5 mg (milligram) blood thinner, on 10/7/2024 and check blood test to measure the blood clotting time (INR).
Stop Warfarin 5 mg on 10/18/2024 and check blood test to measures the INR.

Review of the electronic medication administration records (EMAR) for October showed:
Resident 1 received Warfarin 5mg 1 tablet by mouth on 10/7/2024 and 10/18/2024 at 5:00 PM though there were orders from the physician to stop.

Medications documented as "charted for the next shift" on October 26, 2024, at 8: PM.
Acetaminophen 500 mg 2 tablets by mouth for pain.
Insulin Glargine-YF GN 100 unit/ml (milliliter) SOLN inject 27 units under the skin for diabetes mellitus type 2.
Insulin Lisipro Kwikpen U-100 sliding scale (helps the body turn food into energy and manages the blood sugar levels. Sliding scale: increasing administration of the premeal insulin dose based on the blood sugar level before the meal.) No pre-meal blood glucose reading and no amount of insulin that was given was charted.
Oxycontin 20 mg 1tablet by mouth for pain.
Quetiapine 25 mg 1 tablet by mouth for depression.
Cavilon durable barrier 1.3% cream for skin barrier were charted as given for the next shift.

In an interview on 11/27/2024 at 3:48 PM, Staff E, Regional Director of Operations, stated that the documentation "charted for the next shift" was referring to the progress notes not the medication given. Staff E stated that they met with the staff who made the documentation error.

In an interview on 11/04/2024 at 11:35 AM, Collateral Contact1, (CC1) Doctor's office, stated that they were concerned about the inconsistencies of Resident 1's INR testing since the blood thinner medication dosage was based on the INR test result.

In an interview on 11/4/2024 at 2:37 PM, Staff C, Med Tech, stated that the nurse was the one who checked Resident 1's INR and add new blood thinner dosage order.

In an interview on 11/27/2024 at 10:24 AM, Staff B, Registered Nurse, stated that the ALF was informed in the middle of October that home health would not be doing Resident 1's INR. Staff B stated that they assumed responsibility for Resident 1's INR testing. Staff B stated that they were unable to recall the exact date. Staff B stated that they were taken responsibility on the inconsistencies of the Resident 1's INR testing because on one occasion they ran out of test strips and could not get a strip on time. Staff B stated that another time the whole bottle of strips was expired and had a hard time finding a test strip. Staff B was unaware of the medication errors.

Resident 2

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

Review of Resident 2's negotiated service agreement (NSA) dated 10/30/2024 showed Resident 2 was to receive support from the ALF with medication administration.

Review of the EMAR for the month of October showed Resident 2 was prescribed: Flourometholone (for eye inflammation) 0.1% eye drops twice daily for 1 week, four dosages were not administered on 10/29/2024, 10/31/2024, 11/01/2024 and 11/03/2024 at 5:00 PM, Phenazopyridine HCL (for urinary pain) 100 mg (milligram) 1 tablet three times a day for 2 days, four dosages were not administered on 10/26/2024 at 8:00 AM and 10/27/2024 at 8:00 AM, 5:00 PM and 8:00 PM.

In an interview on 11/05/2024 at 11:20 PM, Collateral Contact 3, (CC3) stated that on 10/25/2024, Resident 2 had a bad cold, urination urgency and very red swollen eyes. Resident 2 was taken to the doctor and was prescribed medications for eye inflammation and urinary discomfort.

In an interview on 11/05/2024 at, Staff B stated that they were unaware Resident 2 had missed dosages of their medications.

Resident 3

Resident 3 was admitted into the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Review of the negotiated service agreement dated 04/12/2024 showed Resident 3 was to receive support from the ALF with medication administration.

Review of the physician's order showed Resident 3 was prescribed to receive Mesalamine (bowel anti-inflammatory) 500 mg, by mouth two times a day for 14 days to start on 10/10/2024 to end 10/23/2024.

Review of October 2024 EMAR showed Resident 3 was prescribed to received Mesalamine 500 mg capsule from 10/19/2024 to 10/23/2024, total of 10 dosages were marked as medication did not arrive.

In an interview on 12/05/2024 at 2:28 PM, Staff B stated that they were unaware Resident 3 had missed dosages of their medications.

This is a recurrent deficiency 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) 02/01/2025 .

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

Lea Wartts Assistant ED — Administrator (or Representative)

1.24.25 — Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Assisted Living Facility (ALF) failed to ensure a system was in place to maintain the cleanliness of 1 of 3 resident's (Resident 1's) rooms. This failure resulted in Resident 1's room being unclean and unsanitary and placed Resident 1 at risk for a diminished quality of life.

Findings included...

Review of the ALF's Title "Disclosure of Services" (DSHS 10-351 Rev. 03/2017) dated 01/02/2023 showed:
"Housekeeping: All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean and comfortable condition."

Resident 1

In an interview on 12/05/2024 at 2:28 PM, Staff B stated that they were unaware Resident 3 had missed dosages of their medications.

This is a recurrent deficiency previously cited on 11/29/2023.

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 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Assisted Living Facility (ALF) failed to ensure a system was in place to maintain the cleanliness of 1 of 3 resident's (Resident 1's) rooms. This failure resulted in Resident 1's room being unclean and unsanitary and placed Resident 1 at risk for a diminished quality of life.

Findings included...

Review of the ALF's Title "Disclosure of Services" (DSHS 10-351 Rev. 03/2017) dated 01/02/2023 showed:
"Housekeeping: All assisted living facilities must maintain your living quarters and other areas you may use in a safe, clean and comfortable condition."

Resident 1

Resident 1 was admitted to the Assisted Living Facility (ALF) on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted].

A negotiated service agreement dated 07/11/2024 showed Resident 2 was needing assistance with weekly housekeeping and daily bed making.

On 11/05/2024 at 3:05 PM, Resident 1's bed was observed with two blue disposable pads, the pillows had no pillow cases with yellowish stains on the pillows, and other than a fitted sheet the bed had no top sheet to cover Resident 1. The wall behind the recliner where Resident 1 was sitting had a twelve-by-twelve piece of drywall patched that was dented. There was paper debris scattered on the living room and bedroom floors, and a plastic straw on the floor. The carpeting had multiple black and dark brown stains and the carpeting seam between living room and bedroom was ripped approximately 18 inches long by 5 inches wide that posed a trip hazard.

In an interview on 11/05/2024 at 12:55 PM, Staff D, Housekeeping staff, stated that they cleaned Resident 1's apartment weekly but the floor got dirty in between the cleaning days. Staff D stated that Resident 1's family did not bring in a top sheet.

In an interview on 11/05/2024 at Staff E, Regional Director of Operations, stated that they would address Resident 1's apartment right away by having the maintenance do a carpet cleaning, painting and other repairs. They were checking for an available apartment that Resident 1 could move in to so they can begin the repairs of Resident 1's current apartment.

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) 02/01/2025

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

Lea Wortts Assistant ED — Administrator (or Representative)

1.21.25 — Date

Resident 1 was admitted to the Assisted Living Facility (ALF) on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted].

A negotiated service agreement dated 07/11/2024 showed Resident 2 was needing assistance with weekly housekeeping and daily bed making.

On 11/05/2024 at 3:05 PM, Resident 1's bed was observed with two blue disposable pads, the pillows had no pillow cases with yellowish stains on the pillows, and other than a fitted sheet the bed had no top sheet to cover Resident 1. The wall behind the recliner where Resident 1 was sitting had a twelve-by-twelve piece of drywall patched that was dented. There was paper debris scattered on the living room and bedroom floors, and a plastic straw on the floor. The carpeting had multiple black and dark brown stains and the carpeting seam between living room and bedroom was ripped approximately 18 inches long by 5 inches wide that posed a trip hazard.

In an interview on 11/05/2024 at 12:55 PM, Staff D, Housekeeping staff, stated that they cleaned Resident 1's apartment weekly but the floor got dirty in between the cleaning days. Staff D stated that Resident 1's family did not bring in a top sheet.

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_____ _____

Administrator (or Representative) Date