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

05/13/2025

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) 59387 (Completion Date 05/13/2025) and 55572 (Completion Date 03/28/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/13/2025 and found no deficiencies.

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

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

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,

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

This document was prepared by Residential Care Services for the Locator website.

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 an unannounced on-site follow-up on 02/28/2025 of:
SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
223 EAST BAKERVIEW ROAD
BELLINGHAM, WA 98226

This document references the following SOD dated: 03/28/2025

The following sample was selected for review during the unannounced on-site visit: 5 of 88 current residents and 0 former residents.

The department staff that inspected 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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 3 of 5 residents (Resident 1, 2, and 3) received medications as prescribed by their physicians. These failures resulted in Residents 1, 2, and 3 not receiving their medications as prescribed, causing distress, and placed them at risk for medical complications.

Findings included…

Review of the ALF's "Medication Assistance" policy 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/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 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

An undated face sheet showed Resident 1 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

A Negotiated Service Agreement (NSA) dated 11/04/2024 showed Resident 1 was to receive medication administration.

Review of the electronic medication administration records (EMAR) for February 2025 showed Resident 1 was prescribed the following medications:
Acetaminophen ER (for pain) 650 mg (milligram) 1 tablet by mouth three times a day;
Potassium Chloride (for low level of potassium in blood) 20 meq (milliequivalent, a unit of measure) 1 tablet daily;
Pregabalin (for nerve and muscle pain) 50 mg 1 capsule two times a day; and
Trazodone (for depression and anxiety) 50 mg 1 tablet at bedtime.

The EMAR dated February 2025 showed Resident 1 did not receive 21 doses of Acetaminophen ER on the following dates: February 10 through 15, and 17; 4 doses of Potassium CHL on February 17,18, 24, 25; 9 doses of Pregabalin on February 12, 13, 14 (morning doses); and 7 doses of Trazodone on February 18, 19, 21, 22, 23, 26, 27. The EMAR showed "medication did not arrive" as the reasons the medications were not given.

In an interview on 02/28/2025 at 11:00 AM, Resident 1 stated that nothing changed on medication concerns. Resident 1 stated that the ALF "still messing around with their medication" by either bringing to them late or missing one or two of their medications. Resident 1 stated they could not remember them all. Resident 1 stated that they were upset that nothing was done about the medication mistakes.

In an interview on 02/28/2025 at 11:48 AM, Staff A, Registered Nurse, stated that they had been auditing the EMAR and providing training to staff in the last 2 months to make sure medications would not run out. Staff A stated that even though they were still finding a few residents who received their medications late, things were improving. Staff A stated that Resident 1's medications were marked as "medication did not arrive" although most of the medications were in the medication cart. Medication technicians

(med techs) were not looking hard enough to find the extra medication. Staff A stated that they had been addressing the problems as they found them during audits.

In an interview on 02/28/2025 at 12:02 PM, Staff B, Medication Technician, stated that most of the medications that were marked as not available were in the cart, but the new med techs were not looking further and just marked them as “medication did not arrive”.

Resident 2

An undated face sheet showed Resident 2 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

An NSA dated 02/10/2025 showed Resident 2 was to receive medication assistance.

Review of the electronic medication administration records (EMAR) for February 2025 showed Resident 2 was prescribed:
Metoprolol tartrate (for high blood pressure)12.5 mg 1 tablet two times a day.

The EMAR dated February 2025 showed Resident 2 did not receive 4 doses of Metoprolol tartrate on the following dates: February 20, 22, 23 & 24. The EMAR showed “medication did not arrive” as the reasons the medication was not given.

In an interview on 03/26/2025 at 10:19 AM, Collateral Contact 2 (CC2) stated that upon review of Resident 2’s medication records, they found some medication discrepancies such as medication did not arrive or refused the medications. CC2 stated that they were concerned on how the ALF managed Resident 2’s medications the ALF agreed to provide.

Resident 3

An undated face sheet showed Resident 3 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

An NSA dated 01/08/2025 showed Resident 3 was to receive medication assistance.

Review of the hospital discharge summary dated [redacted], 2025 showed Resident 3

was to receive the following medications:
Cefdinir (for infection) 300 mg 1 capsule daily for 7 days;
Metronidazole (for infection) 500 mg 1 tablet two times a day for 14 days;
Torsemide (for heart failure) 20 mg 1 tablet daily;
Gabapentin (for peripheral nerve disorder) 300 mg 1 tablet two times a day; and
Loperamide Hydrochloride (for diarrhea) 2 mg 1 capsule three times a day while on antibiotic.

The EMAR dated February 2025 showed Resident 3 did not receive Cefdinir, Metronidazole, Torsemide, or Gabapentin, until 4 days after they were prescribed on [redacted]/2025.

Review of progress notes dated 02/27/2025 at 12:30 PM showed Resident 3's medications were not filled until 02/19/2025.

In an interview on 02/25/2025 at 3:16 PM, Collateral Contact 1 (CC1), Health Care Provider, stated that Resident 3 was admitted at the hospital on [redacted]/2025 for four days due to congestive heart failure (CHF) and shortness of breath. CC1 stated that Resident 3 was discharged on [redacted]/2025 and prescribed Cefdinir 300 mg, Metronidazole 500 mg, Torsemide 20 mg, Gabapentin and Loperamide. CC1 stated that on 02/18/2025 they received a letter from the ALF saying that they needed a doctor’s order, four days after Resident 3 returned to the ALF. CC1 stated that they were concerned on the delay to start Resident 3’s medications and the lack of attention to the ongoing medication problem.

In an interview on 02/28/2025 at 10:25 AM, Staff C, Regional Director of Operations, stated that they had a meeting with the ALF’s pharmacy regarding medication delivery and other issues the ALF was having. Staff C stated that their goal was to make sure residents’ medications were delivered on time.

In an interview on 02/28/2025 at 1:15 PM, Resident 3 stated that they were independent with everything aside from medication management and was relying on the staff to make sure they take the right medications. Resident 3 stated that they did not receive some of their medications for four days and were not feeling well due to their heart, difficulty swallowing, and diarrhea. Resident 3 stated that they were scared to begin with at the hospital and not having their new medications was as scary not knowing what was going to happen to them.

In an interview on 03/26/2028 at 8:54 AM, Staff A, Registered Nurse, stated that they were waiting for a signed order from Resident 3’s doctor before the pharmacy could send the medication out to the ALF.

This is an uncorrected deficiency previously cited on 12/19/2024.

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, 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

Residential Care Services
Investigation Summary Report

Provider/Facility: SPRING CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 1913
Compliance Determination #: 50628
Investigator: Helen Fisher
Investigation Date(s): 11/21/2024 through 12/19/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 155886
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):
1. The Assisted Living Facility (ALF) was short staffed the reason they waited for 45 minutes to received transfer assistance.
2. The Named Resident (NR) did not receive 5:00 PM insulin until 8:30 in the evening.

Investigation Methods:

Sample:	Total residents: 99 Resident sample size: 4 Closed records sample size:
Observations:	NR's appearance and demeanor, living quarter, environment.
Interviews:	NR, NR's spouse, med tech, caregiver.
Record Reviews:	NR's negotiated service agreement, electronic medication administration record (EMAR), progress notes, readmission order, progress notes. Assisted Living Facility (ALF) medication services, emergency call response report.

Investigation Summary:
1) The NR stated that they called for transfer assistance and waited for 45 minutes before their call was answered the evening of November 15th. The staff stated that they were unaware of the issue when they were working the evening of November 15th. The NR call pendant was tested and in working order. Review of emergency call response showed there was no call was made from the NR the whole evening of 11/15. Emergency call response for three of three residents' responses varies from 1 to 7 minutes. Review of the November staffing schedule showed full staffing with 4 caregivers 3 med techs days and evenings, and 3 caregivers, 1 med tech for night shift. No failed practice was identified.
2) The NR stated that they did not receive their insulin medication until 8:30 PM schedule for 5:30 for day PM. The staff stated that the med tech that came from agency was not told by their supervisor that they were not delegated for diabetes

and could not administer the insulin. The ALF's staff stated that they ended up administering the NR's insulin, but it was late. Review of the medication administration record showed the insulin was schedule to be given at 5:00 PM. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A (2210) Medication services. This is a recurrent deficiency previously cited on 11/29/2023.

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 #: 50628
Investigator: Helen Fisher
Investigation Date(s): 11/21/2024 through 12/19/2024
Complainant Contact Date(s): 11/21/2024

Provider Type: Assisted Living Facility

Intake ID: 155573
Region/Unit #: RCS Region 2 / Unit A

Allegation(s):

1) The Assisted Living Facility (ALF) did not update the two Named Residents (NR1's and NR2's) medication administration
record. The ALF had a medication error on both NR1 and NR2.
2) The Named Resident 3 (NR3) was admitted to the ALF without a signed discharge medication order.
3) The ALF was not returning multiple calls from the doctor's office to reconcile medications.

Investigation Methods:

Sample:	Total residents: 99 Resident sample size: 4 Closed records sample size:
Observations:	Residents, environment, medication pass.
Interviews:	Sampled Residents,
Record Reviews:	Both residents negotiated service agreement, electronic medication administration record, progress notes, admission order.

Investigation Summary:

1) The nurse stated that they were aware of the medication error made due to the electronic medication administration (EMAR) discrepancies. Collateral contact stated that the ALF had not been updating both residents' EMAR when they returned to the ALF. The NR1 stated that they were not aware of the mistakes made on their medication. Review of the EMAR showed the NR1was given the medications that had been discontinued while NR2 as needed medication was not added to the EMAR. There was no medication error on NR2. However, staff made multiple medication errors on NR1. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A (2210) Medication services.
2) Interviews indicated that NR3 was admitted to the ALF on [redacted]/2024 from the

hospital. The staff stated that they received NR 3 medications, but the medication order was not signed by the doctor therefore the medications were given to NR3. NR3 was unable to recall if they missed medication dosages. The staff stated that NR3's family came and helped them with their medications until the ALF received the signed order. The NR3's family denied assisting NR3 with their medications and stated that they were not aware NR3 was not receiving medications for 5 days. Failed practice was identified. A citation was written for noncompliance with Washington Administrative Code 388-78A-2210 Medication services.
3) The staff stated that they had a problem with the receptionist in October. The staff stated that there were multiple calls and messages that were not passed on to the nursing department. The staff stated that the receptionist was no longer there. The staff stated that they have not heard of any call issues since. Failed practice was identified. A citation was not written since the ALF had addressed the communication problem before the investigation was conducted.

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

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 11/21/2024 and 11/21/2024 of:

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

This document references the following complaint number(s): 155886, 155115, 155573

The following sample was selected for review during the unannounced on-site visit: 4 of 99 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.

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-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to ensure 2 of 4 residents (Resident 1 and Resident 3) received medications as prescribed by their physicians. These failures resulted in Resident 1 receiving wrong dosages of their diabetes medication (insulin), not receiving insulin on time and receiving discontinued medications during readmission, Resident 3, a new admission, not receiving a total of 25 dosages of their medications, and placed Resident 1 and 3 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/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 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 to the Assisted Living Facility (ALF) on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted].

A negotiated service agreement dated 11/04/2024 showed Resident 1 was to receive medication administration.

Review of the progress notes dated [redacted]/2024 showed Resident 1 was sent to the hospital due to chills and vomiting. Resident 1 was discharged from the hospital to the skilled nursing facility for rehabilitation and was discharged back to the ALF on [redacted]/2024 with a new order.

The readmission physician's order dated [redacted]/2024 showed to administer:
Novolog Flexpen 100 unit/ml (milligram) SOPN 6 units subcutaneously two times a day, hold if not having a meal for diabetes.
Novolog Flexpen 100 unit/ml SOPN subcutaneously before each meal sliding scale 200-249 = 5 units, 250-299 = 8 units, 300-349 = 10 units, 350 + = 12 units.
Metoprolol Succinate ER 25 mg by mouth one daily tablet for high blood pressure.

Review of the electronic medication administration records (EMAR) for November 2024 showed Resident 1 received the following medications without a doctors' order on 11/05/2024 to 11/21/2024.
Novolog Flexpen 100 unit/ml (milligram) SOPN 17 units subcutaneously three times a day before meals, a total of 34 dosages.
Novolog Flexpen 100 unit/ml SOPN 3 units subcutaneously before each meal sliding scale based on the discontinued order. Resident 1 received 3 units , a total of 18 units based on Resident 1's blood sugar level.
Potassium CHL 20 meq (milliequivalent) 1 tablet by mouth daily, a total of 17 dosages.
Pantoprazole 40 mg 1 tablet by mouth daily, a total of 7 dosages..

In addition, Resident 1 did not receive Metoprolol Succinate ER 25 mg tablet, total of 6 doses marked as not filled by the pharmacy.

In an interview on 11/21/2024 at 11:00 AM, Staff A, Registered Nurse, stated that they were unaware of the medication error until they received a call from the doctor's office nurse.

In an interview on 11/21/2024 at 8:23 AM, Collateral Contact 1(CC1) stated that the ALF

was not updating the MAR when they received the readmission order which resulted in the medication errors.

In an interview on 11/21/2024 at 3:28 PM, Staff C, Medication Technician stated that on 11/15/2024 Resident 1 did not receive their insulin until 8:00 PM instead of at 5:00 PM because Staff C stated that they were not informed sooner that the agency med tech was not delegated to administer insulin.

Resident 3

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

A negotiated service agreement dated [redacted]/2024 showed Resident 3 was to receive medication assistance.

The Physician's admit order on [redacted]/2024 showed:
Apixaban 5 mg one by mouth twice a day to prevent blood clots.
Aspirin 81 mg one by mouth daily for heart health.
Atorvastatin 80 mg one by mouth daily for high cholesterol.
Losartan 100 mg one by mouth daily for high blood pressure.
Memantine HCL 5 mg one by mouth daily for cognitive impairment.
Metoprolol Succinate ER 25 mg by mouth one daily, for high blood pressure.
Olanzapine 5 mg one by mouth daily, for agitation and restlessness.
Senna 8.6 mg one by mouth daily.

Review of the November 2024 EMAR showed Resident 3 did not receive the following medications on [redacted]/2024 to 11/16/2024:
Apixaban 5 mg twice a day to prevent blood clots, a total of 8 doses were missed.
Aspirin 81 mg one daily for heart health, a total of 4 doses.
Atorvastatin 80 mg one daily for high cholesterol, a total of 2 doses.
Losartan 100 mg one daily for high blood pressure, a total of 2 doses.
Memantine HCL 5 mg one daily for cognitive impairment, a total of 4 doses.
Metoprolol Succinate ER 25 mg, for high blood pressure, a total of 2 doses.
Olanzapine 5 mg one daily, for agitation and restlessness, a total of 2 doses.
Senna 8.6 mg one daily, 1 dose.

In an interview on 11/21/2024 at 3:43 PM, Staff B, Medication Technician stated that they did not give Resident’s 1 evening medication because there was no signed order or electronic medication administration (EMAR) record. Staff B stated that Resident 1’s medications were available but there was no order. Staff B stated that when they, the MT or the Nurse, receive a new order they transfer the new order to the MAR, but they do not give the medication changes if there is no doctor's signature.

In an interview on 11/21/2024 at 8:23 AM, CC1 stated that Resident 1 was admitted at the ALF on [redacted]/2024. CC1 stated that the ALF called the doctor's office asking for a signed order.

In an interview on 12/12/2024 at 12:15 PM, Staff A stated that Resident 3 did not miss their medications because Resident 3's family provided medication assistance to Resident 3 for 5 days. Staff A stated that the Resident 3's family stayed in Resident 3's apartment.

In an interview on 12/16/2024 at 8:56 AM, Collateral Contact (CC2), representative, stated that Resident 3 did not receive their medications from them or Resident 3's family.

This is a recurring 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)_____ .

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

_____ _____

Administrator (or Representative) Date