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

Cascade Living Group - Ashley Gardens LLC
Ashley Gardens of Mt Vernon
3807 E College Way
Mount Vernon, WA 98273

RE: Ashley Gardens of Mt Vernon License # 1948

Dear Administrator:

This letter addresses Compliance Determination(s) 52360 (Completion Date 12/30/2024) and 49139 (Completion Date 11/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/30/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b

The Department staff who did the on-site verification:
Karen Glover, 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

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 10/22/2024 and 10/22/2024 of:

Ashley Gardens of Mt Vernon
3807 E College Way
Mount Vernon, WA 98273

This document references the following SOD dated: 11/07/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 15 current residents and 1 former residents.

The department staff that inspected the Assisted Living Facility:

Karen Glover, 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.

(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 interview and record reviews the Assisted Living Facility (ALF) failed to have systems in place that ensured 1 of 3 sampled residents (Resident 1) received medications as prescribed. This failure resulted in Resident 1 not receiving three prescribed scheduled medications and one as needed medication (PRN) as ordered and placed Resident 1 at risk of medical complications.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 08/14/2024, the ALF received a citation for an uncorrected deficiency for this regulation. The ALF signed an attestation statement that stated the facility would have a system in place and the deficiency corrected by 09/27/2024.

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 05/31/2024, the 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 07/15/2024.

Resident 1 was admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted]. Resident 1's level of care plan dated 10/13/2024 showed that Resident 1 was to receive complex medication management by the community and staff were to order, store and deliver medications.

Review of Resident 1's Physician's Initial Report and Orders (new admit orders) dated 09/06/2024 showed under medication orders the medical provider put “see attached”. In Resident 1’s chart was a plastic sheet cover where the Physician’s initial report and orders had been placed along with 3 other pages. The 3 other pages was dated 07/14/2024 and was a narrative from a history and physical that included what medications to continue. These 3 pages did not identify Resident 1 anywhere.

On 10/23/2024 at 4:04 PM, Staff A, Wellness Director, stated that the “see attached” was supposed to be a 5-page medication list with the providers clinic name at the top. Staff A stated that these were the admit orders that had been sent to the pharmacy. Staff A was not sure why the 5-page list was not with the initial admit orders in the plastic sheet cover.

Review of the 5-page medication list, dated 09/09/2024 showed the medical providers clinic and address at the top, identified Resident 1 and listed 17 medications. No medical provider signature was noted.

Review of Resident 1's medication administration record (MAR) for the month of September 2024 showed the orders for oxybutynin (treat overactive bladder), losartan, (high blood pressure) and senna (treat constipation) had not been added to the MAR. The sertraline (treat depression) was added on 09/26/2024, after the medical provider noted it was not on the MAR.

Review of Resident 1’s MAR for the month of October 2024 showed the oxybutynin, losartan, and senna had not been added to the MAR.

On 10/24/2024 at 9:14 AM, Staff A stated that the process to verify medication orders starts with Staff B, Staff Nurse, and Staff A is the final look. Staff A stated, “I honestly don’t know what happened.”

On 10/24/2024 at 9:20 AM, Collateral Contact 1 (CC1) stated that they received the medication list that consisted of 5 pages that noted the medical providers clinic at the top and had each medication numbered with a circle drawn around each number. CC1 noted that the medications (oxybutynin, losartan, senna, and sertraline) were all on the original 5-page medication list that they had received from the ALF and the pharmacy should have put them on the MAR.

On 10/24/2024 at 9:35 AM, Staff A stated they received Resident 1’s medications from the previous ALF. Staff A stated they received the losartan, oxybutynin and sertraline medications. Staff A stated that they could not understand why those medications were not included on the MAR.

On 10/28/2024 at 2:00 PM, Collateral Contact 2 (CC2) stated that Resident 1’s medication list was the 5-page document that listed 17 medications.

This is a recuring and uncorrected deficiency previously cited on 05/31/2024 and 08/14/2024.

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, Ashley Gardens of Mt Vernon 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

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 07/24/2024 and 07/24/2024 of:

Ashley Gardens of Mt Vernon
3807 E College Way
Mount Vernon, WA 98273

This document references the following SOD dated: 08/14/2024

The following sample was selected for review during the unannounced on-site visit: 3 of 22 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Karen Glover, 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.

(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 interview and record reviews the Assisted Living Facility (ALF) failed to have systems in place that assured 1 of 3 sampled residents (Resident 1) received medications as prescribed. This failure resulted in Resident 1 not receiving two prescribed medications as ordered and placed Resident 1 at risk of medical complications.

Findings included…

Review of the Department of Social and Health Services (DSHS) Secure Tracking and Reporting System (STARS) showed that on 05/31/2024, 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 07/15/2024.

Resident 1 was admitted to the facility on [redacted]/2024 with multiple diagnoses including [redacted]. Resident 1's service plan dated [redacted]/2024 showed that licensed staff consults with pharmacy and health care providers to oversee Resident 1's medication program and staff was to order, store, and deliver medications per health care providers orders and licensed nurse instructions.

Review of Resident 1's Physician's orders dated [redacted]/2024 included the hospital discharge medication list of 11 medications including Ofloxacin (antibiotic to treat ear infections) 0.3% otic (ear) solution, administer five drops into the affected ears two times a day and Tamsulosin (for urinary retention when one can't completely empty their bladder) 0.4 milligrams (mg), take one capsule daily.

Review of Resident 1's medication administration record (MAR) for the month of July 2024 showed ofloxacin 0.3% otic solution had not been entered on the MAR or given as directed from 07/15/2024 until 07/24/2024 when the complaint investigator found the error.

Review of Resident 1's Physician's Visit Report dated 07/17/2024 showed the medical provider made medication changes including an increase in dose for the Tamsulosin from one capsule daily to two capsules daily.

Review of Resident 1's MAR for the month of July 2024 showed entries for both the previous Tamsulosin order of one capsule daily and the new order for two capsules daily. Entries showed three capsules had been given to Resident 1 for 5 days from 07/19/2024 to 07/23/2024.

On 07/24/2024 at 11:15 AM, Staff B, Wellness Director, stated that Staff A, Executive Director, and Staff C, Community Relations Director, do most of the new admission paperwork and Staff D, Medication Technician, works night shift, and they do the medication reviews. Staff B stated that they see what happened on Resident 1's MAR with the Tamsulosin and that the pharmacy had not deleted the original order after the medical provider had written the new order on 07/19/2024. "Our staff should have caught that."

On 08/14/2024 at 9:45 AM, Staff D stated that they do not review the medications and orders for the new residents. Staff D stated that they have had problems with duplicate orders and the pharmacy not deleting the original orders in the MAR.

This is an uncorrected deficiency previously cited on 05/31/2024.

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, Ashley Gardens of Mt Vernon 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: Ashley Gardens of Mt Vernon
License/Cert.#: 1948
Compliance Determination #: 37826
Investigator: Karen Glover
Provider Type: Assisted Living Facility
Intake ID: 120379
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 03/06/2024 through 05/31/2024
Complainant Contact Date(s): 03/04/2024

Allegation(s):
Named Resident (NR) was given medications not prescribed to them.

Investigation Methods:

Sample:	Total residents: 20 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Nursing staff Executive Director Office Manager Residents Medical provider
Record Reviews:	Incident Report Physician Medication Orders Medication Administrative Record (MAR) Progress Notes

Investigation Summary:
The NR was a new resident and the facility was administering their medications. In the process of ordering the NR's medications from the pharmacy, another resident's medications were also filled for the NR. The NR's family noted the change of cognition and started looking into the medications they were being administered. The facility initiated an investigation and it was determined one sheet of medications received at the pharmacy did not belong to the NR. The facility notified the NR's medical provider and placed the NR on alert charting for monitoring of adverse side effects. The facility identified the issues and has initiated a new process where all physician orders will have the resident name and date of birth on the top of each page. The pharmacy has also put safety checks in place to prevent future incidents from happening. Review of sampled residents showed one resident had not received medications as ordered. WAC 388-78A-2210 (1)(b) 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
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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 03/06/2024 and 04/03/2024 of:

Ashley Gardens of Mt Vernon
3807 E College Way
Mount Vernon, WA 98273

This document references the following complaint number(s): 120379

The following sample was selected for review during the unannounced on-site visit: 4 of 20 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Karen Glover, 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.

(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 have systems in place that assured 2 of 2 sampled residents (Resident 1 & 2) had received medications as prescribed. Resident 1 received medications that were not prescribed by their medical provider and Resident 2 did not receive medications that were prescribed. This failure resulted in both residents not receiving their prescribed medications as ordered and placed both residents at risk of medical complications.

Findings included…

Resident 1

Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted]. Resident 1's service plan, undated, showed that licensed staff consults with pharmacy and health care provider to oversee medication program and facility staff are to order, store and deliver medications per health care providers orders and LN instructions.

Review of the medication error report dated 02/12/2024 showed Resident 1 received the following medications that were not prescribed to them during the days of [redacted]/2024-02/12/2024:

- 3 doses of Mirtazapine 15mg (antidepressant)
- 3 doses of Quetiapine 100mg (antipsychotic)
- 7 doses of Quetiapine 25 mg
- 3 patches of Rivastigmine 4.6 mg/24 hour (treatment for Alzheimer's)
- 3 doses of Trazadone 50 mg (antidepressant)

In an interview on 03/06/2024 at 9:55 AM, Staff B, Nurse, stated that the process for new admissions included the medication list being faxed to the pharmacy after verifying with the medical provider. Staff B stated that the pharmacy enters the medication orders in the

medication administration record in the computer.

In an interview on 03/06/2024 at 11:52 AM, Staff A, Executive Director stated that Resident 1's family requested to review the medications that Resident 1 was taking, after noticing Resident 1 was extremely tired. Staff A stated that it was at that time they discovered Resident 1 was receiving additional medications that had not been prescribed to Resident 1. Staff A stated it was determined that a second list of medications, without a name and date of birth (DOB) on the page, had been faxed to the pharmacy at the same time and was thought to belong to Resident 1.

In an interview on 04/04/2024 at 3:23 PM, Collateral Contact 3 (CC3) stated that the pharmacy had received 6 pages of medication orders for Resident 1. CC3 stated the page without a patient name and DOB should have never been accepted.

Resident 2

Resident 2 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted]. Resident 2's service plan, undated, showed that licensed staff consults with pharmacy and health care provider to oversee medication program and facility staff are to order, store and deliver medications per health care providers orders and LN instructions.

Review of Resident 2's medication administration record for the month of February showed that Resident 2 did not receive the following medications during the days of 02/13 thru 02/17/2024:

- 3 doses of Mirtazapine 15mg
- 4 doses of Quetiapine 100 mg
- 4 doses of Trazadone 50 mg
- 5 doses of Donepezil 10mg (treatment for dementia)
- 8 doses of Atorvastatin 40mg

In an interview on 05/01/2024 at 11:26 AM, Staff A stated that Resident 2's medical provider wanted to verify some of the orders and told staff to hold Resident 2's medications until the orders could be verified. Staff A could not provide documentation of a verbal or written order reflecting this directive.

In an interview on 05/02/2024 at 9:03 AM, Collateral Contact 1 (CC1), primary care physician, stated that they saw Resident 2 at the facility on 02/20/2024 and reconciled medications from pharmacy and medical providers lists. CC1 wrote orders clarifying Resident 2's medications.

In an interview on 05/14/2024 at 11:59 AM, CC3 stated that when residents are first admitted to the ALF, the pharmacy gets their orders, they are put in their profile and then

the electronic MAR is provided to the facility. The pharmacy will then ask what medications need to be filled, often residents have medications from their last facility. CC3 stated that the ALF did not order any medications for Resident 2 until 03/07/2024.

In an interview on 05/17/2024 at 10:08 AM, Staff C, Registered Nurse, stated that they documented "withheld per Dr/Nurse orders" on Resident 2's MAR because they were waiting for admission orders to be reconciled.

In an interview on 05/31/2024 at 2:54 PM Collateral Contact 2 (CC2) stated that they talked with the other medical provider in their office and there is no evidence of a written or verbal order being given to the facility to hold Resident 2's medications.

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, Ashley Gardens of Mt Vernon 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