STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***

**AMENDED**
05/28/2024

NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY LLC
NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
3425 Boone Road SE
Salem, OR 97317

RE: NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY License # 1995

Dear Administrator:

This letter addresses Compliance Determination(s) 41148 (Completion Date 05/20/2024) and 35056 (Completion Date 03/14/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/20/2024 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-2650-2, WAC 388-78A-2730-1-a, WAC 388-78A-2730-1-b, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2

The Department staff who did the on-site verification:
Michelle Mcglon, Nursing Consultant Institutional
Jamie Singer, Field Manager

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
**License/Cert.#:** 1995
**Compliance Determination #:** 35056
**Investigator:** Michelle Mcglon
**Investigation Date(s):** 01/10/2024 through 03/14/2024
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 116685
**Region/Unit #:** RCS Region 2 / Unit J

**Allegation(s):**
1. The Assisted Living Facility (ALF) had water damage from burst pipes that occurred two weeks ago.
2. The ALF did not have 3 day supply of food and water.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 49<br>Resident sample size: 2<br>Closed records sample size: |
| **Observations:** | Residents<br>Food supply |
| **Interviews:** | Maintenance staff<br>Nursing staff<br>Executive Director |
| **Record Reviews:** | State reporting log<br>Facility policies |

**Investigation Summary:**
1. Interview and record review showed the ALF failed to notify the Department when fire watch was initiated. The ALF failed to document fire watch observations every 30 minutes as instructed by the local fire department and the ALF's policy.
2. In an interview, the Executive Director stated that the emergency drinking water for the residents was stored in the hot water tanks. Observation showed the ALF had canned food availabe for emergencies.

**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:** NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
**License/Cert.#:** 1995
**Compliance Determination #:** 35056
**Investigator:** Michelle Mcglon
**Investigation Date(s):** 01/10/2024 through 03/14/2024
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 113265
**Region/Unit #:** RCS Region 2 / Unit J

**Allegation(s):**
1. The Named Resident (NR) had a cluttered apartment at the Assisted Living Facility (ALF).

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 49<br>Resident sample size: 2<br>Closed records sample size: |
| **Observations:** | Identified resident<br>Resident rooms<br>Staff to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff<br>Executive Director |
| **Record Reviews:** | State reporting log<br>Resident Records |

**Investigation Summary:**
1. Observation showed the ALF had removed items to ensure the NR's safety while in the apartment and in case of an emergency. In an interview, the NR stated that things had been moved and stored. The ED stated that the NR had recently moved to a higher level of care.

**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:** NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
**License/Cert.#:** 1995
**Compliance Determination #:** 35056
**Investigator:** Michelle Mcglon
**Investigation Date(s):** 01/10/2024 through 03/14/2024
**Complainant Contact Date(s):**

**Provider Type:** Assisted Living Facility

**Intake ID:** 113711
**Region/Unit #:** RCS Region 2 / Unit J

**Allegation(s):**

1. The Named Resident (NR) was being mentally and verbally abuse at the Assisted Living Facility (ALF).
2. The ALF were not giving the NR medications, resulting in falls.
3. The ALF threatened to discharge the NR from the facility, while in rehab.
4. The NR had requested a larger apartment to accommodate their needs and oxygen tanks.
5. The ALF told the NR to be cost-effective and save money, the resident needed to accept the price that was given.
6. The NR feels neglected and had serious injuries at the ALF.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 49<br>Resident sample size: 2<br>Closed records sample size: |
| **Observations:** | Identified resident<br>Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Nursing staff |
| **Record Reviews:** | State reporting log<br>Facility policies<br>Resident Records |

**Investigation Summary:**

1. Observation showed the NR was comfortable and had no fears. Sampled residents and staff denied mental and verbal abuse.
2. Interview and record review showed the ALF failed to safe medication system in place that led to missed medications.
3. In an interview, the NR stated that they had received a 30 days notice to the NR for

nonpayment of rent. The NR had returned to the ALF following inpatient stay in rehab.
4. Observation showed the NR had been moved to a larger apartment. The NR stated that they had moved to another apartment months ago.
5. In an interview, the Executive Director (ED) stated that the NR had a balance that had not been resolved. The ED stated a discharge notice had been issued to the NR.
6. Observation showed the NR was comfortable and had no fears. Sampled residents and staff denied mental and verbal abuse.

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**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
***20311 52nd Ave W, Suite 100, Lynnwood, WA 98036***



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 01/10/2024, 01/10/2024, 01/29/2024, 03/11/2024 and 03/11/2024 of:

NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY
1907 201ST PLACE SE
BOTHELL, WA 98012

This document references the following complaint number(s): 113711, 110141, 113265, 116685

The following sample was selected for review during the unannounced on-site visit: 2 of 49 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michelle Mcglon, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer
Residential Care Services

03/25/2024
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) 3/28/2024 Date

**WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:**

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

**This requirement was not met as evidenced by:**

Based on interview, and record review the Assisted Living Facility (ALF) failed to notify the Department when three sprinkler heads burst, and Fire Watch was initiated by the local fire department (LFD). This failure places 49 residents, staff and visitors at risk for harm during an emergency.

Findings included...

Review of the ALF's, "Emergency Preparedness Policy", dated 08/29/2023, showed the Executive Director would assign an employee trained in fire prevention observation and in notifying occupants, and Department of Social and Health Services (DSHS) of the inoperable fire extinguishing system.

In an interview, on 01/29/2024 at 2:53 PM, Staff C (Maintenance Director) stated that three sprinkler heads had burst in the wet system during inclement weather on 01/14/2024 Staff C stated that the ALF was unaware the burst had affected their fire extinguishing system until the LFD responded. Staff C stated that the LFD had placed the ALF on a fire watch (a period of time when a group of dedicated staff circulate through the affected areas of a building looking for signs of fire) until the issue was resolved. Staff C stated that he did not notify the Department hotline.

Record review of the Departments Secure Tracking and Reporting Systems, on 01/29/2024, showed no record of the ALF reporting the implementation and directives from the LFD to initiate a fire watch.

In an interview, on 02/09/2024 at 2:09 PM, Staff A (Executive Director) stated that she did not notify the Department as required.

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-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:**

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

**This requirement was not met as evidenced by:**

Based on interview, and record review the Assisted Living Facility (ALF) failed to notify the Department when three sprinkler heads burst, and Fire Watch was initiated by the local fire department (LFD). This failure places 49 residents, staff and visitors at risk for harm during an emergency.

Findings included…

Review of the ALF's, "Emergency Preparedness Policy", dated 08/29/2023, showed the Executive Director would assign an employee trained in fire prevention observation and in notifying occupants, and Department of Social and Health Services (DSHS) of the inoperable fire extinguishing system.

In an interview, on 01/29/2024 at 2:53 PM, Staff C (Maintenance Director) stated that three sprinkler heads had burst in the wet system during inclement weather on 01/14/2024 Staff C stated that the ALF was unaware the burst had affected their fire extinguishing system until the LFD responded. Staff C stated that the LFD had placed the ALF on a fire watch (a period of time when a group of dedicated staff circulate through the affected areas of a building looking for signs of fire) until the issue was resolved. Staff C stated that he did not notify the Department hotline.

Record review of the Departments Secure Tracking and Reporting Systems, on 01/29/2024, showed no record of the ALF reporting the implementation and directives from the LFD to initiate a fire watch.

In an interview, on 02/09/2024 at 2:09 PM, Staff A (Executive Director) stated that she did not notify the Department as required.

**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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) ~~March 13, 2024~~ April 28 * MKM

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

Administrator (or Representative) 3/20/2024 Date

**WAC 388-78A-2730 Licensee's responsibilities.**

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

**This requirement was not met as evidenced by:**

Based on interview, and record review, the Assisted Living Facility failed to ensure they implemented the fire watch (required within all areas, when there is a system impairment that would require a fire protection system) initiated by the local fire department (LFD) following burst pipes that effected their fire extinguishing system. This failure places 49residents, staff and visitors at risk for harm during an emergency.

Findings included...

Review of the ALF's, "Emergency Preparedness Policy", dated 08/29/2023, showed the Executive Director would assign an employee trained in fire prevention observation and in notifying occupants, and Department of Social and Health Services (DSHS) of the inoperable fire extinguishing system. The designated employee's duties include checking areas affected by the fire/fire system outage, to include storage areas, hazardous areas, resident rooms, employee work areas, break rooms, employee work areas and exit corridors. This employee will have no other duties other than the patrol of the community. The employee will patrol the community every 30 minutes and document the fire watch.

In an interview, on 01/29/2024 at 2:53 PM, Staff C (Maintenance Director) stated that three sprinkler heads had burst in the wet system during inclement weather on 01/14/2024. Staff C stated that the ALF was unaware the burst had affected their fire extinguishing system until the LFD responded. Staff C stated that the LFD had placed the ALF on a Firewatch (a period of time when a group of dedicated staff circulate through the affected areas of a building looking for signs of fire) until the issue was resolved. Staff C stated that

**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, NORTH 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-2730 Licensee's responsibilities.**

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

**This requirement was not met as evidenced by:**

Based on interview, and record review, the Assisted Living Facility failed to ensure they implemented the fire watch (required within all areas, when there is a system impairment that would require a fire protection system) initiated by the local fire department (LFD) following burst pipes that effected their fire extinguishing system. This failure places 49residents, staff and visitors at risk for harm during an emergency.

Findings included…

Review of the ALF's, "Emergency Preparedness Policy", dated 08/29/2023, showed the Executive Director would assign an employee trained in fire prevention observation and in notifying occupants, and Department of Social and Health Services (DSHS) of the inoperable fire extinguishing system. The designated employee's duties include checking areas affected by the fire/fire system outage, to include storage areas, hazardous areas, resident rooms, employee work areas, break rooms, employee work areas and exit corridors. This employee will have no other duties other than the patrol of the community. The employee will patrol the community every 30 minutes and document the fire watch.

In an interview, on 01/29/2024 at 2:53 PM, Staff C (Maintenance Director) stated that three sprinkler heads had burst in the wet system during inclement weather on 01/14/2024. Staff C stated that the ALF was unaware the burst had affected their fire extinguishing system until the LFD responded. Staff C stated that the LFD had placed the ALF on a Firewatch (a period of time when a group of dedicated staff circulate through the affected areas of a building looking for signs of fire) until the issue was resolved. Staff C stated that

he did not notify the Department hotline.

Record review of the ALF's Fire Watch Log (FWL), initiated on 01/14/2024 at 3:00 AM, showed the fire watch observation was to be completed every 30 minutes as per the fire watch instructions from the LFD. The designated staff was to observe and document, their findings or actions taken, with every 30-minute fire watch rotation. The fire watch was to consist of tours of the facility, including the attic, to be "constant but recorded at least half-hourly.

Record review of the ALF's FWL, dated 01/14/2024, showed the facility documented intervals of one hour instead of the required 30-minute rotations. The FWL showed on 01/17/2024 from 3:00 PM to 4:00 PM there was no documentation of the observed findings or actions taken. The FWL showed on 01/17/2024 from 5:00 PM to 10:00 PM there was no documentation of the observed findings or actions taken. The FWL had no documentation at all after 10:00 PM on 01/17/2024. The FWL stated that the fire watch can only be cancelled by the Fire Marshal upon review of repairs.

Record review of a Field Work Order, dated 01/15/2024, showed the ALF were to continue fire watch until the vendor returned to the facility to restore the dry system once the piping had thawed. Another Field Work Order, dated 01/19/2024, signed by Staff A showed the ALF were on fire watch until the vendor returned to the facility to restore the dry system.

In an interview, on 03/12/2024 at 12:05 PM, Staff A (Executive Director) confirmed the FWL had not been filled out with the required information every 30 minutes. Staff A stated the repairs had not been completed for approximately 2 weeks after 01/14/2024.

Record review showed no FWL completed after 01/17/2024. There was no FWL completed during the approximate 2-week period of repair.

**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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) May 13, 2024 April 28, 2024 xelN

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

Administrator (or Representative) 3/20/2024 Date

he did not notify the Department hotline.

Record review of the ALF's Fire Watch Log (FWL), initiated on 01/14/2024 at 3:00 AM, showed the fire watch observation was to be completed every 30 minutes as per the fire watch instructions from the LFD. The designated staff was to observe and document, their findings or actions taken, with every 30-minute fire watch rotation. The fire watch was to consist of tours of the facility, including the attic, to be "constant but recorded at least half-hourly.

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Record review of a Field Work Order, dated 01/15/2024, showed the ALF were to continue fire watch until the vendor returned to the facility to restore the dry system once the piping had thawed. Another Field Work Order, dated 01/19/2024, signed by Staff A showed the ALF were on fire watch until the vendor returned to the facility to restore the dry system.

In an interview, on 03/12/2024 at 12:05 PM, Staff A (Executive Director) confirmed the FWL had not been filled out with the required information every 30 minutes. Staff A stated the repairs had not been completed for approximately 2 weeks after 01/14/2024.

Record review showed no FWL completed after 01/17/2024. There was no FWL completed during the approximate 2-week period of repair.

**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-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-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 interview and record review the Assisted Living Facility (ALF) failed to ensure implementation of safe medication services for 1 of 1 resident (Resident 1) when there was no communication with the pharmacy to resolve unavailable medication issues. This resulted in Resident 1 not receiving prescribed medications and placed them at risk of a decline in health status.

Findings included...

Record review of an Assessment, dated 11/22/2023, showed the ALF admitted Resident 1 with multiple medical diagnoses including [redacted] and [redacted].
Review of a Resident Service Plan, dated 10/27/2023, showed the ALF managed Resident 1's medications including administration and ordering.

Review of a Medication Administration Record (MAR) dated December 2023 showed these medications were not given to Resident 1: Cyclobenzaprine (used to treat pain and stiffness) was not given from 12/07/2023 through 12/10/2023. Linzess (used to treat irritable bowel syndrome) was not given from 12/17/2023 through 12/20/2023. Morphine Extended-Release (used to treat moderate to severe pain around the clock) was not given from 12/04/2023 through 12/06/2023. Morphine Immediate Release 15 MG (used to treat moderate to severe pain within 30 minutes) was not given from 12/05/2023 through 12/07/2023. Potassium (used to treat and prevent low blood potassium) was not given from 12/05/2023 through 12/06/2023. Refresh Ointment (used relief intense eye dryness) was not given from 12/06/2023 through 12/31/2023. Xiidra (used to treat dry eye) was not given from 12/20/2023 through 12/31/2023. Record review of Resident 1's December 2023 MAR showed the ALF staff had documented regarding all the missed medications that it was not given due to it not being delivered from the pharmacy.

Review of a MAR dated January 2024 showed these medications were not given to Resident 1: Methocarbamol was not given from 01/01/2024 through 01/13/2024. Lidocaine patch (topical used to treat pain) was not applied from 01/01/2024 through 01/13/2024. Xiidra was not given from 01/01/2024 through 01/29/2024. Refresh Ointment was not given from 01/01/2024 through 01/28/2024. Diclofenac (use to treat pain) was not given from

**WAC 388-78A-2210 Medication services.**

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**This requirement was not met as evidenced by:**

Based on interview and record review the Assisted Living Facility (ALF) failed to ensure implementation of safe medication services for 1 of 1 resident (Resident 1) when there was no communication with the pharmacy to resolve unavailable medication issues. This resulted in Resident 1 not receiving prescribed medications and placed them at risk of a decline in health status.

Findings included…

Record review of an Assessment, dated 11/22/2023, showed the ALF admitted Resident 1 with multiple medical diagnoses including [redacted] and [redacted].
Review of a Resident Service Plan, dated 10/27/2023, showed the ALF managed Resident 1's medications including administration and ordering.

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Review of a MAR dated January 2024 showed these medications were not given to Resident 1: Methocarbamol was not given from 01/01/2024 through 01/13/2024. Lidocaine patch (topical used to treat pain) was not applied from 01/01/2024 through 01/13/2024. Xiidra was not given from 01/01/2024 through 01/29/2024. Refresh Ointment was not given from 01/01/2024 through 01/28/2024. Diclofenac (use to treat pain) was not given from

01/06/2024 through 01/08/2024. Hydroxychloroquine 200 MG (immunosuppressive drug used to treat joint pain and malaria) was not given from 01/22/2024 through 01/29/2024. Record review of Resident 1's January 2024 MAR showed the ALF staff had documented regarding all the missed medications that it was not given due to it not being delivered from the pharmacy.

In an interview, on 01/29/2024 at 1:66 PM, Staff B (Registered Nurse) stated that Resident 1 had missed these medications in December of 2023 and January of 2024 due to nonpayment to the pharmacy. Staff B stated the ALF did not have the medications to give to Resident 1 as the pharmacy would not re-fill them.

In an interview, on 02/22/2024 at 3:55 PM, when asked if Staff B followed up with the pharmacy to confirm medications were missing medications due to Resident 1's non-payment she said she did not.

In an interview, on 02/26/2024 at 8:06 AM, Collateral Contact 1 (CC1- Representative of Resident 1's Pharmacy) stated that the pharmacy would not hold any prescription medications for nonpayment. Resident 1's missing medications were not due to non-payment.

Record review showed no documentation the ALF attempted to refill missing medications.

This is a recurring deficiency previously cited on 01/14/2022, 03/29/2023, and 06/26/2023.

**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, NORTH CREEK RETIREMENT & ASSISTED LIVING COMMUNITY is or will be in compliance with this law and / or regulation on (Date) May 13, 2024 April 28, 2024

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

Administrator (or Representative) 3/28/2024 Date

01/06/2024 through 01/08/2024. Hydroxychloroquine 200 MG (immunosuppressive drug used to treat joint pain and malaria) was not given from 01/22/2024 through 01/29/2024. Record review of Resident 1's January 2024 MAR showed the ALF staff had documented regarding all the missed medications that it was not given due to it not being delivered from the pharmacy.

In an interview, on 01/29/2024 at 1:56 PM, Staff B (Registered Nurse) stated that Resident 1 had missed these medications in December of 2023 and January of 2024 due to nonpayment to the pharmacy. Staff B stated the ALF did not have the medications to give to Resident 1 as the pharmacy would not re-fill them.

In an interview, on 02/22/2024 at 3:55 PM, when asked if Staff B followed up with the pharmacy to confirm medications were missing medications due to Resident 1's non-payment she said she did not.

In an interview, on 02/26/2024 at 8:06 AM, Collateral Contact 1 (CC1- Representative of Resident 1's Pharmacy) stated that the pharmacy would not hold any prescription medications for nonpayment. Resident 1's missing medications were not due to non-payment.

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**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