STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Caring Places Management, LLC
HERITAGE HOUSE BUCKLEY
28833 State Route 410 E
Buckley, WA 98321

RE: HERITAGE HOUSE BUCKLEY License # 2012

Dear Administrator:

This letter addresses Compliance Determination(s) 62139 (Completion Date 07/15/2025) and 56451 (Completion Date 04/03/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/15/2025 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, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:
Nareet Bajwa, NCI-ALF Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Allied Health Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HERITAGE HOUSE BUCKLEY
License/Cert.#: 2012
Compliance Determination #: 56451
Investigator: Nareet Bajwa
Investigation Date(s): 03/17/2025 through 04/03/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 169816
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
Medication error

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 1 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident-to-resident interactions Resident behaviors Care equipment
Interviews:	Resident staff
Record Reviews:	Resident Characteristic Roster Medication administration records (MAR) Staff records Staff progress notes Medical records (lab reports, H & P summary)' Incident log / reports, Facility P & P care plan In-service training

Investigation Summary:
Per record review, interviews with staff, Assisted Living Facility (ALF) failed to ensure that residents received their medication as ordered, failed facility practice identified. See Statement of Deficiency dated 04/03/2025.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Statement of Deficiencies	License #: 2012	Compliance Determination # 56451
Plan of Correction	HERITAGE HOUSE BUCKLEY	Completion Date
Page 1 of 4	Licensee: Caring Places Management, LLC	04/03/2025

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 03/17/2025 of:

HERITAGE HOUSE BUCKLEY
28833 State Route 410 E
Buckley, WA 98321

This document references the following complaint number(s): 169816

The following sample was selected for review during the unannounced on-site visit: 1 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nareet Bajwa, NCI-ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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: 04/08/2025

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: 4/15/25

WAC 388-78A-2210 Medication services.

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

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

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

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

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted Living Facility (ALF) failed to ensure that 1 of 1 Resident (Resident 1 [R1]) received their medication as ordered. This failure placed residents in the ALF at risk for poor health outcomes.

Findings included...

Record review of "Missing or unavailable medication procedure policy," undated," stated, "No resident should ever miss dose of medication. It is our responsibility to obtain medications. All Medication aids are to follow medication refill procedure and re-order all medications 7-10 prior to running out."

Record review of "Caring places management| Policies & Procedures- Medication: Refill

Procedure," undated, stated, " If the prescribed medication is provided through the community used pharmacy, the prescribed medications will be auto filled by the pharmacy and arrive to the community within 48 hours of the last dose on hand."

Review of R1's Info sheet showed that R1 was admitted to the ALF on [redacted]/2019 with the diagnosis to include [redacted] ([redacted]).

Review of R1's March 2025 Medication Administration Record (MAR) showed an order of divalproex sodium (seizure medication) 125mg starting from 01/18/2024, scheduled twice a day at 7:00am to 10:00am and 7:00pm to 8:00pm. There was no record of administration of divalproex sodium on 03/01/2025 at 7:00am to 10:00am, it said waiting on pharmacy, and no documentation at 7pm to 8pm, on 03/02/2025 at 8:10pm and on 03/03/2025 at 8:25am, it said waiting on pharmacy delivery. MAR showed an order of levetiracetam (seizure medication) 500mg starting from 01/08/2024, scheduled twice a day at 7:00am to 10:00am and 7:00pm to 10:00pm. There was no record of administration of levetiracetam on 03/01/2025 at 7am to 10am, it said waiting on pharmacy delivery and no documentation at 7pm to 10pm. MAR showed an order of doxycycline hyclate (urinary tract infection prevention medication) 100mg starting from 01/08/2024, scheduled once daily at 7:00am to 10:00am. There was no record of administration of doxycycline on 03/01/2025 and 03/03/2025, it said waiting on pharmacy delivery. MAR showed an order of gabapentin (nerve pain medication) 300mg starting from 01/08/2024, scheduled three times a day at 8:00am, 12:00pm, 8:00pm. There was no record of administration of gabapentin on 03/01/2025 at 8:00am, 12:00pm, it said waiting on pharmacy and at 8:00pm, no documentation, on 03/02/2025 at 8:10pm and on 03/03/2025 at 8:25am, it said waiting on pharmacy delivery.

Review of the R1's "After-visit summary" dated 03/02/2025 from CHI Franciscan Hospital showed that on 03/02/2025 divalproex last given at 4:45am and levetiracetam last given at 4:41am to R1.

During an interview on 03/17/2025 at 12:06pm, R1 stated that she missed three or four days of medicine. R1 stated that the facility staff took her to the hospital. R1 stated that this happened because pharmacy was mailing to the doctor at wrong address. R1 stated that now everything is good and taken care of.

During an interview on 04/03/2025 at 12:29pm, Collateral Contact 1(CC1), Medical Assistant stated that on 02/27/2025, facility faxed us R1's medication list because we requested that. CC1 stated that on 03/01/2025, we received a fax from the facility for medication refill. CC1 stated, "I do not see any other fax from pharmacy or facility for medication refill in February 2025."

During an interview on 03/17/2025 at 12:17pm, Staff A, Administrator stated that R1 ran out of four medications on 03/01/2025 and was sent out to the hospital on

03/02/2025 at 3am due to a seizure aura (a brief, distinct sensation or experience that precedes a seizure). Staff A stated that on 03/02/2025, R1 was given IV bolus medication for seizure in hospital and R1 came back to the facility on the same day. Staff A stated on 03/03/2025, R1 received her medication refill from pharmacy. Staff A stated that pharmacy faxed us on 02/25/2025 that they cannot refill R1's medications because they needed a new signed prescription from the doctor. Staff A stated that the pharmacy reached out to the wrong doctor. Staff A was asked who is responsible for faxing to the doctor. Staff A stated that medication technicians, nurses and pharmacy do the refill order from the doctor, it's a team effort. Staff A was asked how many days prior to last dose staff was supposed to re-order the medicine. Staff A stated that as per policy, medication technicians were supposed to order medication 7-10 days prior to running out. Staff A was asked if medication technician followed the policy. Staff A stated that these medications are auto filled by pharmacy and the medication technicians do not need to put refill order for these medications. Staff A stated that medication technicians only do refill orders for PRN (when required) medications. Staff A stated that as soon as pharmacy notified us on 02/25/2025 that they were unable to reach R1's doctor to get signed prescription then we stepped in and worked as team. Staff A stated that in-service education was done with all staff by regional nurse.

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, HERITAGE HOUSE BUCKLEY is or will be in compliance with this law and / or regulation on (Date) 5/17/2025.

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

Kelley [illegible] 4/15/25

Administrator (or Representative) Date