



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Caring Places Management, LLC
Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

RE: Easthaven Villa License # 2144

Dear Administrator:

This letter addresses Compliance Determination(s) 28488 (Completion Date 08/24/2023) and 22878 (Completion Date 06/14/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/24/2023 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371, WAC 388-78A-2640-1-a, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2640-3, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3-a, WAC 388-78A-2120-4

The Department staff who did the off-site verification:

Celeste Vashey, ALF LTC Licenser

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

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



Residential Care Services Investigation Summary Report

Provider/Facility: Easthaven Villa

Provider Type: Assisted Living Facility

License/Cert.#: 2144

Compliance Determination #: 22878

Intake ID: 77475

Investigator: Celeste Vashey

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 05/31/2023 through 06/14/2023

Complainant Contact Date(s):

Allegation(s):

1) Facility reported concern that 10 residents in the memory care had experienced diarrhea and vomiting.

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 7 Closed records sample size: 1
Observations:	Identified resident Resident rooms Resident care equipment Staff to resident interactions
Interviews:	Identified resident Nursing staff Identified staff Family members
Record Reviews:	Medical records State reporting log Facility policies

Investigation Summary:

1) Based on interview and record review failed practice found regarding reporting residents change in condition to their physician and representative, documenting the date, time, relationship of the individual contacted when a change of condition occurred; Monitoring residents well being. Identifying changes in the resident, evaluating them, and taking appropriate action in response to their changed needs.

Conclusion / Action:

- ☒ 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: Easthaven Villa

Provider Type: Assisted Living Facility

License/Cert.#: 2144

Compliance Determination #: 22878

Intake ID: 78958

Investigator: Celeste Vashey

Region/Unit #: RCS Region 3 / Unit E

Investigation Date(s): 05/31/2023 through 06/14/2023

Complainant Contact Date(s):

Allegation(s):

- 1) Concern Residents/Staff are smoking with 25 ft of the building.
- 2) Concern facility doors are difficult to open in AL Dining Room.
- 3) Concern loose carpet is in the AL Dining room that contributed to a fall.
- 4) Concern of cleanliness of AL Dining room.
- 5) Concern residents cannot ask for more food and it is not approved by a dietician.
- 6) Concern residents are being bullied in activities.

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 7 Closed records sample size: 1
Observations:	Identified resident Residents Activities Dining Resident rooms Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Maintenance staff Housekeeping staff Kitchen staff
Record Reviews:	Medical records Grievance log State reporting log Incident investigation Facility policies Staff training records

Investigation Summary:

- 1) Could not substantiate. The smoking gazebo is 25 ft away from the building. Staff had identified some residents who smoke outside of there doors. Staff will remind the resident not to, completed updatead smoking assessments, and have stated the resident could be evicted if they smoke outside of there doorway.
- 2) Could not substantiate. The facility has a plan in place to help residents open the doors as needed. They have a plan to get automatic door for the dining room in the future.
- 3) Could not substantiate. The facility mat was firmly against the ground. There were no observations of loose carpeting within the facility.
- 4) Could not substantiate. The facility caregivers/kitchen staff clean after every meal. The staff sweep the floors at night.
- 5). Could not substantiate. The residents can ask for more food. The menu is approved by dietician.
- 6) Based on observation and interview failed practice found. The facility will be cited for failing to investigate incidents. The facility did not start an investigation after it was learned a residents family was filming another resident. They did not start an investigation after a resident poured water on another resident for walking too slowly.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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DSHS RCS REGION 3
VANCOUVER

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2144	Compliance Determination # 22878
Plan of Correction	Easthaven Villa	Completion Date
Page 1 of 14	Licensee: Caring Places Management, LLC	06/14/2023

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 05/31/2023 and 06/15/2023 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 77475, 78958

The following sample was selected for review during the unannounced on-site visit: 7 of 75 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC Licenser

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros

Residential Care Services

06/27/2023

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.

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



Administrator (or Representative)

7/6/2023

Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to investigate and document investigative actions, determine circumstances of an event, implement measures to prevent future situations, and protect residents during the course of an investigation for 1 of 4 sampled residents (Resident 2). This failure placed the resident at risk of abuse within the facility.

Findings included...

WAC 388-78A-2020 Definitions - "Abuse means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult..."

Record review of the Assisted Living Facility Guidebook, dated February 2018, showed all alleged incidents of abuse, neglect, abandonment, significant injuries of unknown source, or personal and or financial exploitation must be thoroughly investigated. The investigation was done to determine what occurred and to make necessary changes to the provision of care and services to prevent reoccurrences.

Record review of the facility policy, titled, "Resident Incidents & Investigations", undated, showed all incidents required a thorough quality assurance investigation to determine what occurred, to determine if any abuse had occurred, and to implement measures, as needed to prevent recurrence. Timely completion of the investigation showed staff must immediately report and investigate all incidents in accordance with state regulations. Any

staff member may initiate an investigation, but it was the responsibility of the resident care coordinator to complete and investigate. It was the responsibility of the nurse to investigate further as required, recommend preventative measures, and to sign off on the investigation. The administrator had final review, completion, and sign off responsibilities.

Record review of Resident 1 (R1)'s Face Sheet, undated, showed R1 admitted into the facility on [REDACTED]/2020. R1's face sheet showed R1 had diagnoses of [REDACTED] and [REDACTED].

Record review of R1's Resident Progress Notes, dated 03/22/2023, showed an unknown staff member wrote care staff reported after dinner they noticed R1's niece was recording Resident 2 (R2) on their phone and R1 and R1's daughter were laughing and talking with R2 in the dining room. The administration was notified.

Record review of R1's Resident Progress Notes, dated 03/23/2023, showed an unknown staff member wrote care staff informed me this morning on 03/20/2023 that R1 had walked behind R2 and was annoyed they were not moving fast enough down the hallway. R1 poured the water out of their water bottle onto R2's back. R2 stated they were not happy about getting soaked. The administration was notified.

Record review of R2's Face Sheet, undated, showed R2 admitted into the facility on [REDACTED]/2022. R2's face sheet showed R2 had a diagnosis of [REDACTED].

Record review of R2's Resident Progress Notes, dated 03/03/2023 – 06/05/2023, showed no reference to R1's family filming R2 on 03/22/2023 and no reference that R1 had poured their water on R2 on 03/20/2023.

Record review of the facility's untitled document, dated 02/28/2023 – 05/29/2023, showed an incident accident log list that did not document any incidents between R1 and R2 on 03/20/2023 and 03/22/2023.

In an interview on 06/06/2023 at 2:38 PM, Staff D, Resident Care Coordinator, confirmed the unknown staff member who wrote R1's resident progress notes on 03/22/2023 and 03/23/2023 was Staff E, Medication Aide. Staff D stated that they were unaware that R1 and their family had filmed R2. Staff D stated that they were unaware R1 had poured water onto R2 while in the hallway. Staff D stated they were unsure if an investigation was completed for both of these incidents. Staff D stated an internal investigation should have been completed regarding these two incidents within 1-3 days of when they had occurred.

In an interview on 06/08/2023 at 10:30 AM, Staff E, Medication Aide, confirmed they had written R1's resident progress notes on 03/22/2023 and 03/23/2023. Staff E cannot remember which caregiver reported the two incidents to them regarding R1 and R2. Staff E

stated that they had reported both incidents to the administration. Staff E stated they were unsure if an investigation was completed regarding the two incidents they had reported.

In an interview on 06/06/2023 at 3:10 PM, Staff A, Administrator stated an investigation should had been completed after it was reported on 03/22/2023 that R1's niece had recorded R2 on their phone and R1 and R1's daughter were laughing and talking with R2 in the dining room. Staff A stated an investigation should had been completed on 03/23/2023 after it was reported that R1 poured their water bottle onto R2's back. Staff A confirmed an investigation was not completed for either of these incidents.

In an interview on 06/08/2023 at 10:19 AM, Staff C, Resident Care Coordinator, stated if a resident filmed another resident, then the facility would have a conversation with the resident about respecting the other residents' privacy. Staff C stated an investigation would not have been completed if residents were filming other residents. Staff C stated if a resident poured water onto another resident purposefully, then an investigation should had been completed to investigate why the incident occurred. Staff C confirmed an investigation was not completed for either of these incidents regarding R1 and R2. Staff C stated the incident to where R1 poured water onto R2 sounded familiar. Staff C said Staff B, Assistant Administrator, looked into the incident and said when R1 poured water onto R2 it was an accident. Staff C stated R2 was not soaked with water and that only a couple of drops of water had spilled onto R2.

In an interview on 06/12/2023 at 4:45 PM, Collateral Contact 1 (CC1), Emergency Contact for R2, stated that they were unaware that R2 had been filmed by another resident while in the facility. CC1 stated they were unaware R2 had gotten water poured on them by another resident.

In an interview on 06/12/2023 at 2:14 PM, Staff B, Assistant Administrator, stated that they were aware that R1's niece had filmed R2, and that they should had completed an investigation. Staff B stated that they were aware of the situation that R1 had poured water onto R2. Staff B stated the incident was reported to them almost immediately after it happened. Staff B stated that they had verbally talked to R1 and R2 about what had happened. Staff B stated an investigation had not been completed regarding the incident, but it should have been investigated.

This is a recurring deficiency previously cited on 04/13/2021.

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

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 7/28/23.

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

Mike McHenry
Administrator (or Representative)

7/6/2023
Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure the residents representative and their physician were notified and that the facility documented when they were notified for 5 of 5 sampled residents (Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7) when they had experienced a change of condition. This failure placed residents at risk of their representatives and physicians of being uninformed of the resident's conditions and unable to make informed decisions related to the resident's care.

Findings included...

Record review of the facility policy, titled, "Notification of Change in Resident's Condition", undated, showed it was the facility policy to keep all appropriate individuals and agencies informed if there were any changes in the resident's condition. The facility staff were to notify the residents next of kin, guardian, or agency responsible for, or designated by the resident, as soon as possible regarding a change of condition. The facility staff were to document in the resident's record the date and time the individuals were notified and the relationship of those individuals to the resident.

Record review of the facility policy, titled, "Resident Alerts", undated, showed all incidents, changes of conditions, changes in medication, etc. required an enhanced monitoring of the resident and potential changes in care. The medication aide would notify the resident care

coordinator and the resident representative when the resident was placed on alert charting. The resident care coordinator could extend the alert charting end date if directed by another medical professional.

Record review of a line list sent from the facility via email to the Local Health Jurisdiction, dated 04/06/2023, showed 10 memory care residents that had experienced diarrhea (loose watery stools that occur more frequently than normal) and vomiting (forcefully expelling the stomach's contents out of the mouth). The line list showed Resident 7 (R7)'s onset symptoms of diarrhea and vomiting developed on 04/04/2023. Resident 4 (R4) and Resident 5 (R5)'s onset symptoms of diarrhea and vomiting developed on 04/05/2023. Resident 3 (R3) and Resident 6 (R6)'s onset symptoms of diarrhea and vomiting developed on 04/06/2023. The line list indicated none of the residents needed to go to the hospital.

R3

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED]/2019. R3's face sheet showed R3 had a diagnosis of [REDACTED].

Record review of R3's Resident Progress Notes, dated 04/01/2023 – 04/29/2023, showed no notes that indicated R3 had experienced diarrhea and vomiting starting on 04/06/2023 and no documentation that R3's representative or physician were notified.

Record review of R3's Resident Alerts, dated 03/20/2023 – 04/02/2023, showed no notes that R3 had experienced diarrhea and vomiting starting on 04/06/2023 and no documentation that R3's representative and their physician were notified.

Record review of R3's faxes showed no fax was submitted to their physician that notified them R3 had experienced diarrhea and vomiting starting on 04/06/2023. In an interview on 06/07/2023 at 11:24 AM, Collateral Contact 3 (CC3), Power of Attorney (POA) for R3, stated they had not received a call from the facility staff that R3 had been sick with diarrhea and vomiting during the month of April 2023.

R4

Record review of R4's Face Sheet, undated, showed R4 admitted into the facility on [REDACTED]/2021 and had a diagnosis of [REDACTED].

Record review of R4's Resident Progress Notes, dated 03/21/2023 – 04/04/2023, showed no notes that R4 had experienced diarrhea and vomiting starting on 04/05/2023 and no documentation that R4's representative and their physician were notified.

Record review of R4's Resident Alerts, dated 03/21/2023 – 04/04/2023, showed no notes that R3 had experienced diarrhea and vomiting starting on 04/06/2023 and no documentation that R4's representative and their physician were notified.

Record review of R4's faxes showed no fax was submitted to their physician that notified them R4 had experienced diarrhea and vomiting starting on 04/05/2023.

In an interview on 06/06/2023 at 2:04 PM, Collateral Contact 2 (CC2), POA for R4, stated they had not received a call from the facility that R4 had experienced diarrhea and vomiting starting on 04/05/2023. CC2 stated they are R4's POA and the facility was supposed to call and notify them about changes related to R4's condition.

R5

Record review of R5's Face Sheet, undated, showed R5 admitted into the facility on [REDACTED]/2023 and had a diagnosis of [REDACTED].

Record review of R5's Resident Progress Notes, dated 04/01/2023, showed an unknown staff member documented, "Care staff informed me that resident [R5] is having loose stools/diarrhea almost every day now. Resident [R5] takes stool softener twice a day. Faxed residents PCP [primary care physician] about possibly lowering how much stool softener [R5] gets or discontinuing stool softener as resident [R5] does have a PRN order for milk of magnesia for constipation. Awaiting response from PCP." Further review of R5's progress notes showed there was no documentation of when or if R5's representative and physician was notified of the onset of symptoms of diarrhea and vomiting starting on 04/05/2023.

Record review of R5's Resident Alerts, dated 03/16/2023 – 03/17/2023, showed no notes that R5 had experienced diarrhea and vomiting starting on 04/05/2023 and no documentation that R5's representative and their physician were notified.

Record review of R5's fax, dated 04/01/2023, showed an unknown staff member faxed R5's physician notification that R5 had loose stools and diarrhea almost every day and requested the physician to lower or discontinued R5's stool softener.

Record review of R5's faxes showed no fax was submitted to their physician that notified them R5 had experienced diarrhea and vomiting starting on 04/05/2023.

R6

Record review of R6's Face sheet, undated, showed R6 admitted into the facility on [REDACTED]/2019 and had a diagnosis of [REDACTED].

Record review of R6's Resident Progress Notes, dated 04/06/2023, showed an unknown staff member wrote R6 had complained of feeling unwell upon waking up. R6 reported their stomach hurt and refused breakfast. R6 was found to have thrown up all over themselves and their apartment. R6 was provided medication.

Record review of R6's Resident Progress Notes, dated 03/20/2023 – 04/19/2023, showed no notes that indicated R6 had experienced diarrhea and vomiting starting on 04/06/2023 and no documentation that R6's representative and their physician were notified.

Record review of Residents Alerts, dated 03/20/2023 – 05/04/2023, showed no notes that R6 had experienced diarrhea and vomiting starting on 04/06/2023 and no documentation that R6's representative and physician were notified.

Record review of R6's faxes showed no fax was submitted to their physician that notified them R6 had experienced diarrhea and vomiting starting on 04/06/2023.

R7

Record review of R7's Face sheet, undated, showed R7 admitted into the facility on [REDACTED]/2020 and had a diagnosis of [REDACTED].

Record review of R7's Resident Progress Notes, 03/09/2023 – 04/27/2023, showed no documentation that R7's representative was notified that they had experienced diarrhea and vomiting starting on 04/04/2023.

Record review of R7's Residents Alerts, dated 03/09/2023 – 04/27/2023, showed no documentation that R7's representative was notified that they had experienced diarrhea and vomiting starting on 04/04/2023.

In an interview on 05/26/2023 at 12:06 PM, Staff D, Resident Care Coordinator (RCC), stated the memory care unit experienced multiple residents who had diarrhea and vomiting for approximately 2-3 days. Staff D stated the facility staff should have notified the residents physicians and their resident representative that they were sick.

In an interview on 05/26/2023 at 12:48 PM, Staff F, Lead Medication Aide, stated that multiple memory care residents had become sick with diarrhea and vomiting in the month

of April 2023. Staff F stated once they were notified a resident had experienced a change of condition they would notify the resident care coordinator, the administrator, the resident's physician, and the residents representative.

In an interview on 06/06/2023 at 2:38 PM, Staff D, RCC, stated that the memory care residents who had experienced diarrhea and vomiting should have had their physicians notified via fax and their representatives should have been notified via telephone. Staff D confirmed R3, R4, R5, R6, and R7 had been impacted by diarrhea and vomiting.

In an interview on 06/06/2023 at 3:10 PM, Staff A, Administrator, stated that they were aware that R3, R4, R5, R6, and R7 had been impacted by diarrhea and vomiting. Staff A stated Staff B, Assistant Administrator, sent a line list to the local health jurisdiction of all the residents that were impacted.

In an interview on 06/12/2023 at 2:14 PM, Staff B, Assistant Administrator, stated the memory care residents who had been impacted by the diarrhea and vomiting should have had their representative notified. Staff B stated a fax to their physician should have been completed to notify them of the resident's condition.

This is a recurring deficiency previously cited on 06/10/2021.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 7/28/23.

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

Mary M. M. M.
Administrator (or Representative)

7/16/2023
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to identify and address changes in a resident's condition for 5 of 5 sampled residents (Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). This failure placed residents at risk of unmet care needs.

Findings included...

Record review of the facility policy, titled, "Resident Alerts", undated, showed all incidents, changes of conditions, changes in medication, etc. required an enhanced monitoring of the resident and potential changes in care. The medication aide would start the alert charting process. Documentation of the observed resident would be done once daily. This could be completed by follow up notes, alert notes, or as a progress note. Under "Diarrhea" section showed record observations every shift until resolved. Take vitals each shift. Record observations of dizziness, lack of tears, dry tongue, confusion, pain and document how many stools per shift. Encourage fluids, especially clear liquids. Under "Nausea/Vomiting" section showed record observations every shift until resolved. Take vitals each shift. Record how many times the resident vomited and observations of dry heaving, dizziness, pain, color of vomit, fever, ability to swallow, and fluid intake. Encourage clear fluids.

Record review of a line list sent from the facility via email to the Local Health Jurisdiction, dated 04/06/2023, showed 10 memory care residents that had experienced diarrhea and vomiting. The line list showed Resident 7 (R7)'s onset symptoms of diarrhea and vomiting developed on 04/04/2023. Resident 4 (R4) and Resident 5 (R5)'s onset symptoms of diarrhea and vomiting developed on 04/05/2023. Resident 3 (R3) and, Resident 6 (R6)'s onset symptoms of diarrhea and vomiting developed on 04/06/2023.

R3

Record review of R3's Face Sheet, undated, showed R3 admitted into the facility on [REDACTED]/2019 and had a diagnosis of [REDACTED].

Record review of R3's Resident Progress Notes, dated 04/01/2023 – 04/29/2023, showed no notes that R3 had experienced diarrhea and vomiting starting on 04/06/2023.

Record review of R3's Resident Alerts, dated 03/20/2023 – 04/02/2023, showed no notes that R3 had experienced diarrhea and vomiting starting on 04/06/2023.

Record review of R3's faxes showed no fax had been submitted to their physician that notified them R3 had experienced diarrhea and vomiting starting on 04/06/2023.

In an interview on 06/07/2023 at 11:24 AM, Collateral Contact 3 (CC3), Power of Attorney

(POA) for R3, stated they had not received a call from the facility that R3 had been sick with diarrhea and vomiting during the month of April 2023.

R4

Record review of R4's Face Sheet, undated, showed R4 admitted into the facility on [REDACTED]/2021 and had a diagnosis of [REDACTED].

Record review of R4's Resident Progress Notes, dated 03/21/2023 – 04/04/2023, showed no notes that R4 had experienced diarrhea and vomiting starting on 04/05/2023.

Record review of R4's faxes showed no fax had been submitted to their physician that notified them R4 had experienced diarrhea and vomiting starting on 04/05/2023.

In an interview on 06/06/2023 at 2:04 PM, Collateral Contact 2 (CC2), POA for R4, stated they had not received a call from the facility that R4 had experienced diarrhea and vomiting starting on 04/05/2023. CC2 stated that they are R4's POA and the facility was supposed to call and notify them about changes related to R4's condition.

R5

Record review of R5's Face Sheet, undated, showed R5 admitted into the facility on [REDACTED]/2023 and had a diagnosis of [REDACTED].

Record review of R5's Resident Progress Notes, dated 04/01/2023, showed an unknown staff member documented, "Care staff informed me that resident [R5] is having loose stools/diarrhea almost every day now. Resident [R5] takes stool softener twice a day. Faxed residents PCP [primary care physician] about possibly lowering how much stool softener [R5] gets or discontinuing stool softener as resident [R5] does have a PRN order for milk of magnesia for constipation. Awaiting response from PCP."

Record review of R5's Resident Progress Notes showed there were no other notes to review regarding that R5 had experienced diarrhea and vomiting starting on 04/05/2023.

R6

Record review of R6's Face sheet, undated, showed R6 admitted into the facility on [REDACTED]/2019 and had a diagnosis of [REDACTED].

Record review of R6's Resident Progress Notes, dated 04/06/2023, showed an unknown

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staff member wrote R6 had complained of feeling unwell upon waking up. R6 reported their stomach hurt and refused breakfast. R6 was found to have thrown up all over themselves and their apartment. R6 was provided medication.

Record review of R6's Resident Progress Notes, dated 03/20/2023 – 04/19/2023, showed no other notes related to R6's vomiting or diarrhea that started on 04/06/2023.

Record review of R6's faxes showed no fax had been submitted to their physician that notified them R6 had experienced diarrhea and vomiting starting on 04/06/2023.

R7

Record review of R7's Face sheet, undated, showed R7 admitted into the facility on [REDACTED]/2020 and had a diagnosis of [REDACTED].

Record review of R7's Resident Progress Notes, dated 04/04/2023, showed Staff F, Lead Medication Aide, wrote R7 had experienced vomiting and diarrhea. R7 was encouraged to stay in bed and rest with frequent checks from the caregivers. R7's physician was faxed and asked to provide medication for the symptoms.

Record review of R7's Resident Progress Notes, dated 04/05/2023, showed an unknown staff member wrote R7's physician sent over a medication to help with the diarrhea and vomiting. The note stated the resident would be placed on alert to monitor for any adverse reactions to the new medication once it had arrived and the initial dose had been administered.

Record review of R7's Resident Progress Notes, 03/09/2023 – 04/27/2023 showed no other notes related to R7's vomiting and diarrhea, or if R7 had received the medication prescribed by their physician.

Record review of R7's fax, dated 04/04/2023, showed Staff F, Lead Medication Aide, faxed R7's physician and stated R7 had loose stools and vomited. Staff F asked for an order to help with R7's symptoms.

In an interview on 05/26/2023 at 12:06 PM, Staff D, Resident Care Coordinator (RCC), stated the memory care unit experienced multiple residents who had diarrhea and vomiting for approximately 2-3 days. Staff D stated the facility staff should have made a progress note and alert charted on the residents who were sick.

In an interview on 05/26/2023 at 12:35 PM, Staff G, Caregiver, stated they were not

familiar with multiple memory care residents getting sick with diarrhea and vomiting in the month of April 2023. Staff G stated if a resident had experienced diarrhea and vomiting that it would be considered a change of condition and they would notify the medication aide on shift. Staff G stated the medication aide would place the resident on alert and they would determine how long the resident needed to be on alert for.

In an interview on 05/26/2023 at 12:29 PM, Staff H, Caregiver, stated they cannot recall multiple memory care residents getting sick with diarrhea and vomiting in the month of April 2023. Staff H stated if a resident had experienced diarrhea and vomiting, they would be placed on alert. Staff H stated the medication aide completed the charting for the residents.

In an interview on 05/26/2023 at 12:48 PM, Staff F, Lead Medication Aide, stated that multiple memory care residents had become sick with diarrhea and vomiting in the month of April 2023. Staff F stated once they were notified a resident had experienced a change of condition, they put the resident on alert and progress note the resident's condition until the symptoms subside.

In an interview on 06/06/2023 at 2:38 PM, Staff D, RCC, stated that the memory care residents who had experienced diarrhea and vomiting should have had a progress note written and been placed on alert charting. Staff D stated the diarrhea and vomiting lasted approximately 1-2 days for each effected resident. Staff D stated each effected resident should have been placed on alert during the duration of their illness. Staff D stated they recalled R6 and R7 being sick because they had been significantly impacted by the diarrhea and vomiting. Staff D stated R3, R4, and R5 had been minimally impacted with one singular incident of vomiting or diarrhea. Staff D stated a progress note should have been written regarding a singular incident of vomiting or diarrhea. Staff D stated if the diarrhea or vomiting did not persist then more than likely the resident would not be placed on alert.

In an interview on 06/12/2023 at 2:14 PM, Staff B, Assistant Administrator, stated the memory care residents who were impacted by diarrhea and vomiting should have had alert charting completed for them.

This is a recurring deficiency previously cited on 02/16/2022.

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, Easthaven Villa is or will be in compliance with this law and / or regulation on (Date) 7/28/23.

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

Statement of Deficiencies

License #: 2144

Compliance Determination # 22878

Plan of Correction

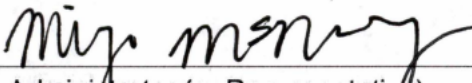
Easthaven Villa

Completion Date

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Licensee: Caring Places Management, LLC

06/14/2023


Administrator (or Representative)

7/6/2023
Date



Assisted Living & Memory Care Community
311 Cullens Street NW
Yelm, WA 98597

Plan of Correction

Statement of Deficiencies Report Dated June 28, 2023

Deficiency	Actions	Responsible Person(s)	Due Date	Completed Date
WAC 388-78A-2371 Investigations	Medication aides and RCCs will be retrained on the investigation procedure.	Admin and [REDACTED] LPN	7/28/23	
WAC 388-78A-2640 Reporting significant change in a resident's condition	Retraining to be completed with medication aides and RCCs on change in conditions and when/who to report these changes. Retrain on alert charting protocols, importance of placing on alert when necessary. Retrain on alert charting protocol once quarterly. Retraining on when RCCs initiate significant change protocol.	Admin and [REDACTED] LPN [REDACTED] RCC, [REDACTED] RCC, and [REDACTED] LPN [REDACTED] RCC, [REDACTED] RCC, and [REDACTED] LPN Admin and [REDACTED] LPN	7/28/23	



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WAC 388-78A-2120 Monitoring residents' well-being	Retraining with all staff on Stop and Watch forms and who to report changes to. LPN/RN to monitor investigations, alerts, and progress notes to ensure resident well-being and safety.	[REDACTED] RCC and [REDACTED] RCC [REDACTED] RN and [REDACTED] LPN	7/28/23	
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