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

07/18/2025

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

RE: Easthaven Villa # 2144

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 62798 (Completion Date 07/18/2025) and 56956 (Completion Date 04/11/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/18/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Easthaven Villa
Provider Type: Assisted Living Facility
License/Cert.#: 2144
Compliance Determination #: 56956
Intake ID: 169276
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 03/26/2025 through 04/11/2025
Complainant Contact Date(s):

Allegation(s):
Quality of Care/Treatment: Report of resident eloping from the community unattended.

Investigation Methods:

Sample:
Total residents: 71
Resident sample size: 3
Closed records sample size: 1

Observations:
Identified resident
Residents
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Resident Care Coordinator
Administrator

Record Reviews:
State reporting log
Incident investigation
Facility policies
Care Plan
Incident reports
Progress Notes
Assessments

Investigation Summary:
Facility failed to provide to supervision to a memory care unit resident resulting in the resident eloping from the community numerous times. The facility failed to notify CRU and conduct an investigation when the resident left the community. Failed practice identified.

Conclusion / Action:

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

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

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 03/26/2025 and 04/14/2025 of:

Easthaven Villa
311 Cullens St NW
Yelm, WA 98597

This document references the following complaint number(s): 169276, 170541, 171914

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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.

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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

(c) Safely operate the assisted living facility; and

(d) Operate in compliance with state and federal law, including, but not limited to, chapters 7.70 , 11.88, 11.92, 11.94, 69.41, 70.122, 70.129, and 74.34 RCW, and any rules promulgated under these statutes.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to implement policies and procedures to keep residents safe, address elopement behaviors, ensure appropriate supervision of residents, and report incidents to the complaint resolution unit (CRU) for 1 of 3 residents (Resident 1 [R1]) reviewed. These failures resulted in Resident 1 repeatedly eloping from the facility placing their health and safety at risk and placed all residents residing in the memory care unit at risk for elopement and injuries.

Findings included…

Record review of the facility policy, titled, “Elopement & Wandering,” dated 10/28/2024, showed, “The facility’s objective is to ensure resident safety, utilizing the least restrictive means available. It is the policy of the Facility to identify residents who walk or wheel about unrestricted and are a threat to leave the facility due to their confusion. Wandering is an acceptable activity within the secure confines of the Facility….All caregivers will be able to identify and recognize potential wanderers and will be able to intervene and redirect as necessary…The Facility will provide a safe area for wanderers by providing…Sufficient trained staff to monitor our residents.” Under the section titled, “Elopement”, showed, “showed when a resident is believed to be missing, an elopement is presumed and the following steps must be taken: a) if a temporary absence had been logged, the log entry will be used to determine appropriate contact numbers. These will be called in an attempt to locate the resident. b) An immediate search of the building and grounds will be initiated. All areas will be checked…If the building search is unsuccessful, surrounding streets and yards will be checked. c) If the resident is not located in the initial search (section b), local police, Administrator, Nurse, the respective state departments, and the family (section e) will be notified…f) Once the resident is located, he/she will be assessed for injuries. The reason for and method of elopement will be investigated. g) The Administrator and Nurse will discuss the facts relating to the elopement and a determination will be made as to the continued appropriateness of the Resident given the constraints of the Facility. h) In order to support the Resident safely, given his/her changing needs, appropriate changes will be made to the Service Plan… j) an investigation will be initiated and completed.”

Record review of the facility policy, titled, “Abuse, Neglect and Exploitation,” undated, showed, “This Community will not tolerate verbal, physical, mental, or physical abuse, including involuntary seclusion of an Resident by any staff member, other Resident or visitor to the Community. An injury of unknown cause will be investigated as potential abuse.” Under “Procedures,” showed 1) “Mandatory reporting: (b) Any staff member who has a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation of a vulnerable adult has occurred will notify the following departments immediately: In Washington- Department of Social and Health Services (DSHS) Hotline: 1-800-562-6078 OR- Online (Washington only). Under 2) “Quality Assurance Investigation Report,” showed, a) “A Quality Assurance Investigation Report will be prepared for an abuse, neglect or exploitation to determine the circumstances of the event and to determine appropriate preventative measures to prevent similar future situations. The following information will be gathered:
i) Resident information with relevant history
ii) Location and date/time of incident management
iii) Notification as appropriate (eg. Physician, family, Complaint Resolutions Unit)
iv) Description of incident
v) Contributing factors (if known)
vi) Assessment of Resident
vii) Signature of Person completing investigation
viii) Review and signature of management
b) Administrator will further investigate and implement measures to prevent re-occurrence.

Under 4) “Documentation,” showed a) “The staff member will document the incident in the Resident health record and action of the staff related to the incident including preventative measures put in place to assure safety.

Review of (Washington Administrative Code) WAC 388-78A-2670, showed : “Services by resident for assisted living facility.
If a resident performs services for the assisted living facility, the assisted living facility must ensure:
(1) The resident freely volunteers to perform the services without coercion or pressure from staff persons;
(2) The resident performing services does not supervise, or is not placed in charge of, other residents; and
(3) If the resident regularly performs voluntary services for the benefit of the assisted living facility, the volunteer activity is addressed in the resident's negotiated service agreement.”

Record review of an email dated 03/27/2025 at 11:30AM, showed Staff A, Administrator, was asked if staff would follow the abuse, neglect, and exploitation policy when an elopement occurred, Staff A responded, yes.

Review of Department Records showed that a report was made by the facility on 02/27/2025 at 1:05PM notifying the Department that on 02/26/2025 at 12:00PM Resident 1 (R1) had been escorted over to the assisted living unit to have lunch with their friend. Around 4:30PM the memory care unit medication aide on duty was walking near the front of the memory care building and saw R1 walking towards the front doors. Medication aide asked R1 what they were doing and R1 stated, “I got bored and went for a walk.” Report stated R1 did not appear to know how to find their way back. Medication Aide was able to get R1 back into the memory care unit. R1 denied leaving the parking lot but was unsupervised during her trip from assisted living to memory care. Resident 2 (R2), R1’s friend in assisted living, stated R1 told them they were going outside to look around. R2 became worried when R1 didn’t come back after 5 minutes. Prior to this incident, R2 was asked to pull the call light if R1 left the room unattended. R2 did not pull the call light.

Review of Department Records showed that a report was made by the facility on 03/18/2025 at 5:25PM notifying the Department that on 03/18/2025 at 9:50AM R1 asked the medication aid if they could go for a walk. Medication Aid asked R1 to wait while Medication Aid (Med Aid) finished their medication pass. R1 became upset and walked over to the front door and punched in the door code and walked out the door. The medication aid followed R1 and were met by the Resident Care coordinator (RCC). The RCC walked with R1 past the front of the AL building and began walking towards the main road. R1 was irritable and told the RCC to “shut up so I can walk in silence.” R1 ignored the RCC’s requests to walk to the Memory care parking lot and they continued walking on the side of the road towards the main road. RCC and Med aid switched off so that the RCC could update the Registered Nurse (RN) and administrator. R1 continued to ignore repeated requests to return to the facility and continued toward the main road. The medication aid walked with R1 to the gas station where they bought snacks.

R1 continued to be angered as they walked back to the building from the gas station. RCC met R1 and the medication aid outside where they tried to persuade R1 to come in due to R1 looking fatigued due to walking for over an hour. R1 refused to go back into memory care but was agreeable to gong to see R2 in assisted living. R1 was escorted by the RCC to R2s room where R1 slammed the door and told the RCC to “get out”. Approximately 5-10 minutes later R1 was seen again outside the assisted living building where R1 exited R2’s back door. R1 had R2’s dog and told staff that they had gotten lost. R2 did not pull the call light or notify staff when R1 went out R2’s back door.

Review of R1’s face sheet, undated, showed that R1 was admitted to the facility on [redacted]/2025. Listed on the face sheet were R1’s diagnosis including [redacted]. Under “risk factors” the box next to “elopement risk or history” was marked.

Review of R2’s face sheet, undated, showed R2 was admitted to the facility on [redacted]/2025.

Record review of R2’s care plan, dated 02/25/2025, under the section, “Activities,” showed R2’s friend (R1) lived in the memory care unit and would visit R2 in assisted living. R2 agreed to notify staff by pulling their call light if R1 exited the apartment. Staff were to respond promptly if the call light was pulled to check if R1 had left R2’s apartment. Staff were to redirect R1 back into R2’s apartment or walk back to memory care.

Review of R1’s assessment, dated 01/09/2025, showed under the section, “Elopement Risk Evaluation,” a list of potential risk factors were listed. Three risk factors were checked to include Medications (Received medications that may increase restlessness), Wandering (Wanders without a sense of purpose or orientation) and Cognitive impairment (Cognitively impaired person with poor decision-making skills, and/or diagnosis). The “yes” box was checked for the question, “Does the resident ambulate independently, with or without the use of assistive devices, either routinely or intermittently.” R1 was considered at risk for elopement if 1 or more potential risk factors were indicated along with a response of “yes” to ambulating. If a resident was deemed a risk for elopement: (1) Community must develop and implement interventions in a resident-specific service agreement. These may include, but are not limited to, the need for a secured setting such as a memory care neighborhood or a GPS (a device that uses the Global Positioning System to determine a user’s exact location and provide navigation information) (2) If this a newly established risk or if the risk has increased, notify regional and home office.

Record review of R1’s Service agreement, dated 01/23/2025, showed, under “Activities,” R1 had an incident recently where they were visiting with her friend in AL (Assisted Living) walked out the back door, and got lost needing staff direction. Due to safety concerns of elopement, an air tag (tracking device) was placed on their phone. Signs were placed in their friends room reminding them to pull the call light when

wanting to leave the room. R1 had another incident on 03/18/2025 where they left [redacted] (R2's room) without staff. Annunciators (an alarm) were placed on R2's doors. AL staff were to monitor for annunciators going off and promptly check as needed. Under the section, "Memory," showed R1 had poor short-term memory. R1 was oriented to their current home but would get lost in unfamiliar locations. R1 had wandering tendencies which were related to their short-term attention span, wanting to look around "new" areas and at different objects. Under the section, "Ambulation," showed R1 tripped over the curb when they were walking from R2's room in assisted living. Staff were to offer a hand when escorting up/down curbs or other uneven surfaces. Under the section, "Miscellaneous," showed R1 figured out the code to exit the secured memory care unit and was noted as a, "Huge issue." The Door code was changed and new signs were placed on 03/19/2025.

Record review of R1's incident report, dated 02/26/2025, section titled, "Description of Incident," showed a medication aide was standing in the front foyer and noticed R1 walking towards the memory care unit from assisted living unattended. The medication aid went outside and asked R1 where they were going. R1 reported that they got bored and went for a walk but did not seem to know how to find their way back to where they were going. R1 was redirected back into the memory care unit. Later that evening, R1 became upset yelling, cursing at staff and trying to forcefully open the doors. In the section, "what action will be taken to reduce the possibility of incident recurring," showed Staff were to escort R1 to R2's room, R1 has Apple airtags on their shoe and lanyard, signs had been placed in R2's room to remind R1 not to leave without pulling the call light and there would be frequent checks for safety. Under the section titled, "Summary of Witness Statements," showed R2 stated that after 5 minutes after R1 left they thought to themselves that they should have gone with R1 because they know R1 became easily confused. Despite having concerns, R2 still did not pull the call light to notify staff that R1 left.

Record review of a facility provided document titled, "Emergency Safety Plan", dated 02/27/2025, showed R1 lived in memory care neighborhood and would go to visit their friend in Assisted Living all day, then return to Memory Care Neighborhood for bedtime. R1 left R2's apartment recently and walked back to Memory Care Neighborhood by themself. R2 had agreed to call or notify staff if R1 wanted to leave their apartment, but did not notify staff yesterday.

Record review of R1's incident report, dated 03/18/2025, section titled, "Description of Incident," showed R1 entered the code successfully and exited the secured memory code unit. The medication aid followed R1 where R1 proceeded to walk past the assisted living building to the main road. R1 ignored attempts by staff telling them to shut up so they could walk in silence. Staff were able to convince R1 to walk back to the facility but R1 again changed their mind and turned back around to head to the main road. Medication aide continued to walk with R1 and ended up at the gas station. After going to the gas station, R1 and the medication aid were met by the Resident Care Coordinator (RCC) The RCC tried to convince R1 to go back inside as R1 looked fatigued. R1 refused to go back to memory care but agreed to visit R2 in assisted living. Once inside R2's room, R1 yelled at the RCC to get out and slammed the door. Approximately 5-10 minutes later, R1 was seen outside with R2's dog and told staff they had gotten

lost. R2 did not pull the call light or notify staff when R1 exited the room out the back door. R1 was then escorted back to R2's room and was placed on 1:1 supervision for the rest of the evening.

In an interview on 03/26/2025 at 10:22AM, Staff B, Resident Care Coordinator, stated R1 used to be R2's caregiver and they used to live together prior to moving into the community. Staff B stated they moved to the community due to R1's progressive dementia and R2 needing a caregiver. Staff B stated R1's dementia was bad and they sundown (a phenomenon characterized by increased confusion, agitation, and restlessness that often occurs in the late afternoon and evening in individuals with dementia, particularly those with Alzheimer's disease.) Staff B stated R1 was not happy about living in memory care away from R2. Staff B stated when R1 and R2 moved in the facility, the plan was to allow R1 to go to R2's to visit. Staff B stated that R1 and R2 agreed that if R1 left the room then R2 would pull the cord right away to notify staff. Staff B stated on 02/26/2025, R1 was visiting R2 and left out the back door and was in the parking lot. Staff saw R1 in the parking lot and brought them back into memory care. Staff B was asked who was monitoring R1 to ensure they didn't wander or leave R2's room, Staff B stated they typically don't do one on one supervision. Staff B stated they were doing regular check ins to make sure everything was ok. Staff B stated they had talked to R2 about pulling the cord when R1 left the room and they were aware of that process. Staff B was asked if R1 was safe to leave the community on their own, they stated no. Staff B was asked if R1 was unattended, they stated yes, there was no staff in the room just R2. Staff B was asked if leaving R1 was safe, they stated, at the time R2 was with it and we thought it was ok initially. Staff B was asked if R1 was at risk for elopement, they stated yes, it was on her assessment that they were a risk. Staff B was asked if putting the responsibility on R2 to notify staff if R1 left was appropriate, they stated, R2 requested it. R2 wanted R1 to visit them. Staff B stated we offered for R2 to go to memory care and they declined. Staff B was asked what the process was now for when R1 wants to visit R2, they stated there are Apple airtags on R1's shoe and on their phone lanyard, there were signs on the door for R1 to not leave R2's room and the call light was strung in front of the back door. Staff B was asked if R1 had left R2's room since putting these interventions in place, they stated yes and then the sensor on the door went off and staff were notified.

In an interview on 03/26/2025 at 10:22 AM, Staff A, Executive Director, was asked if the interventions placed were sufficient to keep R1 safe, they stated the only thing we can do is put interventions in place and so far it hasn't been an issue. Staff A stated they were trying to keep them independent because when they get in the way it seems to be a violation of rights and dignity.

In an interview on 03/26/2025 at 10:56AM, R2 was asked if they had friends that come visit them, they stated yes. R2 stated R1 lives at the facility and has serious memory issues. R2 was asked if R1 had ever left their room before, R2 stated they had. R2 stated they thought R1 was going for a walk, they went out the back door and walked outside. R2 stated R1 has done it twice and got lost both times. R2 stated now when R1 was over visiting they were not supposed to let them go out. R2 stated R1 stated they were going to go look around but now they were getting lost. R2 was asked what they were supposed to do when R1 leaves, R2 stated I imagine I'm supposed to call them. R2

then stated “which reminds me, I don’t have a telephone number for the front desk.” R2 was asked how they would call staff if R1 leaves, they stated they had an office number but needed to get one today. R2 was asked if they had any other way to call for staff, they stated they would open the door and look for them and walk to the office. R2 was asked if there were any other ways they would call for staff, they stated there probably was but they didn’t know. R2 was asked if they felt like they were responsible for R1, they stated yes. R2 was asked how that made them feel, they stated they don’t want to be responsible for R1. R2 stated they have become forgetful. R2 was asked why they don’t want to be responsible for R1, they stated they are somewhat disabled and they can’t run after them.

In an observation on 03/26/2025 at 11:18 AM R2’s back door at the top had a white box that appeared to be a sensor. The door was opened. Staff arrived at 11:21AM, 3 minutes later.

In an interview on 03/26/2025 at 11:21AM, Staff C, Medication Aide, arrived to R2’s room. R2 asked Staff C for the front office number. Staff C wrote down the phone number on a piece of paper for R2 and told R2 they can also pull the cord if R1 leaves.

In an interview on 03/26/2025 at 11:27AM, Staff C was asked what the process was when R1 came to visit R2, they stated R2 should pull the call light when R1 tried to leave but they didn’t always do it. Staff C stated that was why door alarms were added. Staff C was asked how many times R1 had left R2’s room, they stated 3-4 times. Staff C was asked if they felt the process to have R1 over to R2’s place was safe, they stated no. Staff C stated R1 has a mind of her own and doesn’t redirect well.

In an observation on 03/26/2025 at 11:46 AM, was a four-digit code posted on the wall to get into the memory care unit.

In an observation on 03/26/2025 at 12:10 PM, the code was posted by the exit to the secure memory care unit, using the spelling of the words in sentences so the reader had to decipher the code.

In a joint interview on 03/26/2025 at 12:15PM, Collateral Contact 1 (CC1), friend/caregiver, stated they were at the facility to watch R1 because R1 didn’t know where they were at. CC1 was asked if R1 had left memory care before, they stated yes numerous times, R1 figured out the code. R1 was asked how far they made it when they left, R1 stated they made it to the gas station and then came back. R1 stated that was a couple weeks ago. CC1 stated R1 has been there twice. CC1 stated over the past weekend the alarms weren’t working. R1 left out the door and walked down to the gas station and when they came back they let themselves in using the code. CC1 stated R2 knew R1 was gone. CC1 was asked how many times R1 left the building, they stated R1 had gone to the gas station twice by themself, the latest time was this past weekend.

In a joint interview with R1 and CC1 03/26/2025 12:32PM, R1 was asked if they remembered leaving the facility, they stated yes. R1 stated it was a nice day and they went for a walk to the 7/11 (convenience store/gas station). R1 was asked how many times they walked to the 7/11, they stated just once. CC1 stated it was twice. CC1 stated R1 was very smart but was very manipulative. R1 was asked how they got out of the memory care unit, they stated they just put the code in and walked out.

In an interview on 03/26/2025 at 12:48PM, Staff D, Housekeeper, was asked what the process was when R1 wanted to go to assisted living to visit another resident, they stated they didn't know, it changed everyday. Staff D stated staff were supposed to keep an eye on R1. Staff D was asked if they knew of a time R1 wandered off, they stated, yes last week. R1 figured out the code and the medication technician (med tech) went with R1 and walked around. Staff D stated then this past Saturday (03/22/2025) R1 left and went to the gas station. Staff D was asked if anyone was with her, they stated no. Staff D stated R1 came back and told on herself. Staff D stated R1 told Staff E, Medication Aide. Staff D was asked if the plan in place for R1 to visit R2 was safe, they stated they don't even know what the plan was, so probably not. Staff D stated R1 just kept on leaving, they get bored. Staff D stated it was not safe if she just takes off by herself. Staff D was asked how many times R1 had taken off, they stated 3 or 4 times, the last time was on Saturday.

In an interview on 03/26/2025 at 1:54PM, Staff E was asked if they worked this past Saturday, they stated they did. Staff E was asked if anyone had left the facility, they stated R1 was in assisted living and entered memory care with another residents dog. Staff E stated R1 told them that they got bored and took the dog for a walk down the street. Staff E stated R1 used the code to get in memory care and then turned around and used the code to leave to go to assisted living. Staff E stated that they had called Staff A immediately. Staff E stated staff in assisted living knew R1 was over in assisted living but the Medication aid was passing medication and the only caregiver there was not near the door alarm. Staff E was asked where R1 went, they stated that R1 told them they took the dog for a walk. Staff E stated R1 had been going to the gas station at the end of the road.

Record review of R1's progress notes, dated 03/22/2025, showed, R1 walked into memory care with R2's dog. R1 stated they got bored and took the dog for a walk down the road and then came to memory care. Staff E called the Administrator. R1 had entered the code to get into memory care and when staff tried to keep R1 in memory care, R1 entered the code to get out and returned to Assisted Living. Staff followed R1 and convinced them to return to memory care unit.

In an interview on 03/26/2025 at 2:26PM, Staff F, Caregiver, was asked if any residents had left the facility unattended, they stated yes many times. Staff F was asked when the last time R1 left the facility unattended, they stated yesterday. Staff F stated that the door alarm went off and they went to go check R2's room where R1 was. Staff F stated when they entered the room R1 came back in through the back door. Staff F stated they explained to R1 that they cant leave without staff. They stated R1 replied that they didn't know. Staff F told R2 that R1 cannot leave without an escort. Staff F

stated that R2 responded that they forgot. Staff F stated the alarm went off a couple more times. R1 was reminded again that they cant leave without an escort and R2 kept saying they forgot. Staff F was asked if they felt the process in place was safe, they stated no. R2 can't remember to tell R1 to pull the cord, its an unsafe situation for both R1 and R2. Staff F was asked if there was a situation that happened this past Saturday, they stated there was. Staff F stated R1 was taken over to assisted living to visit R2. Shortly after, R1 had walked into the memory care unit with R2's dog after they punched in the code. Staff F stated R1 told them that they had walked to the gas station which was on a very busy street. Staff F stated it was very concerning that R1 left by themselves. Staff F stated they notified the med aid and the med aid notified Staff A.

In an interview on 03/26/2025 at 4:36PM, Staff B was asked when the airtags were put in place for R1, Staff B stated on 02/28/2025 after the first incident. Staff B was asked if R1 had eloped before, they stated R1 had. R1 had eloped on 02/26/2025 and on 03/18/2028. Staff B stated both incidents were reported to the department. Staff B was asked if R1 eloped on 03/22/2025, they stated they didn't know exactly and that they were waiting on Staff E to come in to write it up. Staff B was asked if they or Staff A was contacted on Saturday (03/22/2025) regarding R1 leaving the facility, they stated Staff A was. Staff B was asked why the incident wasn't reported to the department, they stated Staff A told Staff E to write a progress note, put them on alert, do an investigation and do a state report. Staff B stated Staff E did not do it and should have. Staff B was asked if an investigation had been done yet, they stated no not yet. Staff B was asked when an investigation should have been done by, they stated it should have been done within 24 hours of the incident happening. Staff B was asked what happened, they stated R1 told staff that they walked to the gas station and back but it hadn't been confirmed. Staff B was asked if they had asked R1 about the incident, they stated R1 told them that they made it to the gas station and back fine. Staff B stated it should have been reported to state. Staff B was asked if it could be viewed as neglectful if a memory care resident was out wandering away from the facility, they stated yes, we are trying our best with our interventions. Staff B was asked how long they thought it could take R1 to make it to the street from R2's room, they stated it could take a minute or 2. Reiterated to Staff B that the cord was pulled earlier and it took staff 3 minutes to come to R2's room. Staff B was asked if something could happen to R1 in three minutes, they stated, it could. Staff B was asked how they were monitoring R1 with the airtags, they stated they were connected to the ipad so if R1 couldn't be found they would open it up and check R1's location. Staff B was asked if the ipads alert when R1 leaves the community, they stated they do not. Staff B was asked if they had staff readily available to go after R1 every time the alarm went off on R2's door, they stated they were trying their best to make it work.

In an interview on 03/27/2025 at 10:40AM, Staff A, was asked at the end of the day, who was responsible for supervising the residents, they stated, our staff.

This is a recurring deficiency previously cited on 08/05/2024 for subsection (1)(b).

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)_____ .

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:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(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 observation, interview and record review, the Assisted Living Facility (ALF) failed to implement systems that support and promote safe medication services, and ensure residents received their medications as prescribed for 1 of 1 residents reviewed (Resident 2 [R2]). This failure placed residents at risk for unsafe medication practices.

Findings included…

Record review of the facility policy, titled, “Medication Administration,” undated, showed “Staff will assist Residents who are on Medication Service A to obtain medication via reminding, coaching or, help to prepare a medication for administration.
Assistance included:
1) Opening a container
2) Using an enabler or placing the medication in the Residents hand
3) Assistance with applying or instilling skin, nose, eye and ear preparation.
4) Steady or guide a Resident’s hand to assist with medications…
Under “Procedure,” showed:
1) Inform the Resident of the reason that you’re coming
2) Unlock medication cupboard
3) Take out medication (mediset, blister pack, etc.) from the cupboard and , open if needed.
4) Hand container to Resident.

5) Instruct/observe Resident. Check to assure prescribed amount was taken.
6) Provide water and observe client swallow pills/apply medication
7) Return medication to the cupboard, lock up and document."

Review of R2's face sheet, undated, showed R2 was admitted to the facility on [redacted]/2025.

Record review of R2's Service Agreement, dated 02/25/2025, under "Medical Care Management," showed, assistance required: Order, store, and dispense medications as ordered by PCP (Primary Care Provider.)

In an observation and interview on 03/26/2025 at 10:56 AM, R2 was observed to have a pill cup with pills in it on a table next them. R2 was asked who brought the cup of pills to them, they stated staff. R2 was asked if staff handed the pills to them and left the room, they stated yes. R2 stated evening staff had them swallow them before they leave.

In interview on 03/26/2025 at 11:21 AM, Staff C, Medication Aide, entered R2's room and stated, "don't forget to take your pills."

Record review of R2's Service Agreement, dated 02/25/2025, showed R2's friend who lived in the memory care unit came to visit R2 in their room at the assisted living daily.

In an interview on 03/26/2025 at 4:36 PM, Staff B, Resident Care Coordinator, was asked what the process was when the medication aid brought residents their medications to their rooms, they stated, they would bring them their pills and watch them swallow them. Staff B was asked if the medication aid would stay with the resident while they took them, they stated yes. Staff B was asked if the medication aid would leave the cup full with medications, they stated they shouldn't. Staff B stated the medication aids should be watching them take their medication if we are giving them to the resident.

In an interview on 03/27/2025 at 10:40 AM, Staff A, Administrator, was asked if R2 received medication assistance from the facility, they stated yes. Staff A was asked what the process was when the medication aid delivered medications to a resident, they stated the medication aid should be staying with the resident watching them take the medications before they sign off that the resident took the medications. Staff A was asked if the medication aid could leave the medication cup on a table next to the resident, they stated they should not do 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, Easthaven Villa 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