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

Spring Ridge Retirement, LLC

Spring Ridge Retirement, LLC
6856 E Portland Ave
Tacoma, WA 98404

RE: Spring Ridge Retirement, LLC License # 2160

Dear Administrator:

This letter addresses Compliance Determination(s) 29491 (Completion Date 09/14/2023) and 19562 (Completion Date 07/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/14/2023 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-2210-2

The Department staff who did the on-site verification:
Michael Goulet, Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Spring Ridge Retirement, LLC
Provider Type: Assisted Living Facility
License/Cert.#: 2160
Intake ID: 67533
Compliance Determination #: 19562
Region/Unit #: RCS Region 3 / Unit D
Investigator: Michael Goulet
Investigation Date(s): 02/07/2023 through 07/11/2023
Complainant Contact Date(s): 02/01/2023, 02/27/2023, 07/12/2023

Allegation(s):

1) Staff did not respond in timely manner to change in condition for resident (stroke)
2) Resident not administered medication (Coumadin, anticoagulant) for four days in December 2022
3) Resident ordered to be served Broccoli but this food was not provided by facility

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size:
Observations:	General environment Resident Condition Residents in their rooms
Interviews:	Residents Staff Collateral Contacts
Record Reviews:	Call Light Log Picture of note Medication Incident Report Medication Pass Detail

Investigation Summary:

1) Per complainant report, the named resident had attempted to contact staff multiple times on the morning of 1/22/23, including writing a note to staff requesting staff to contact the resident's family. Per interview, the named resident stated they had felt unwell on the morning of 1/22/23, but the resident could not remember if they had talked to facility staff at that time. The named resident stated they had written a note, but could not remember what time this was, only that it was "after breakfast", and that staff "knew right away" in relation to the resident's change in condition, later identified as a stroke per resident and facility staff. The named resident could not remember the time of the stroke or staff response, but stated they had no issues with staff responding when called. Record review of facility call light logs show that the resident did use their call pendent to contact staff five times on 1/22/23; at 3:10am, 5:37am,

9:58am, 10:40am and 12:23pm. Staff were noted to spend at least seven minutes with the resident for each of the call pendent activations. Per interviews with facility staff, the resident's change in condition was not noted "around lunch" and that no prior issues were noted during resident to staff contact prior to this time. Per interviews, each staff involved clearly noted that there were no signs of stroke noted prior to this time, and that they understood what the signs and symptoms of a stroke were. Record review of facility progress notes show that the resident had been transported to hospital prior to 1:14pm on 1/22/23 due to the resident being 'not able to talk and breathing slow', supports the timeline described by facility staff and shown by the facility call light log final pendent activation at 12:23pm. No information available served to support that the facility did not act in a timely manner once the resident's change in condition was noted.
2) Per record review of the facility Medication Incident Report, it was noted that the named resident did not receive Coumadin from 12/21/22 through 12/24/22, and that the facility medication technicians did not follow up on this issue until the facility was notified of the issue. Record review of the facility Medication Pass Detail showed that staff noted that the medication was missed and 'held' from 12/21/22 until 12/24/22, and only on 12/24/22 did staff note that action was taken and the resident's pharmacy contacted in order to ensure receipt of the medication. The medication was noted to be given as ordered on 12/25/22. Note: per facility staff and record review of pharmacy delivery record, the medication was noted to be delivered to another facility (noted as delivered by driver, but signed for by a staff that is known to work at another assisted living facility), but the facility did not take action other than to note the med as being unavailable from 12/21/22 through 12/24/22.
Cited as per WAC 388-78A-2210 (2) Medication Services.
3) Per interviews, both facility staff and staff at the named resident's anticoagulation clinic stated that the resident did not have any order for broccoli to be served. Facility staff stated that broccoli was offered to the named resident and that the resident had refused this. Per interview, the named resident could not state if they had refused Broccoli or not. No failed practice substantiated in regard to this allegation.

Conclusion / Action:

- ☐ 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

PO Box 99250, Lakewood, WA 98496

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 02/07/2023 and 02/07/2023 of:

Spring Ridge Retirement, LLC
6856 E Portland Ave
Tacoma, WA 98404

This document references the following complaint number(s): 67533

The following sample was selected for review during the unannounced on-site visit: 5 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Michael Goulet, 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 — 07/13/2023 (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.

Administrator (or Representative)

7/24/23
Date

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 reviews, the Assisted Living Facility (ALF) failed to provide anticoagulant medication (Coumadin, a blood thinner) to 1 of 5 residents (Resident 1) for a period of four days from 12/21/2022 through 12/24/2022. This failure placed the resident at risk of physical harm.

Findings included...

During an interview on 02/07/2023 at 10:30am, the Executive Director (Staff A) stated that Resident 1 (R1) did not receive Coumadin during the period stated (12/21/2022 through 12/24/2022) due to a pharmacy delivery error (medication was noted to be delivered to another facility).

Record review on 02/07/2023 at 2:50pm of the facility's Medication Incident Report related to the missed administration of Coumadin for R1 showed that facility "Med Techs did not follow up until the RCC (Resident Care Coordinator) was told and then contacted pharmacy." It also noted that the "medication (Coumadin) was not re-ordered in a timely manner" by facility staff.

Record review on 02/07/2023 at 2:50pm of the facility's own Medication Pass Detail showed that the medication (Coumadin) was noted as 'missed' on 12/21/2022 and as 'held' on 12/22/2022 through 12/24/2022. Under the section of this form for staff notes related to action taken for missing or non-administered medication, there was no entry for the dates 12/21/2022 through 12/23/2022. The staff notes section did not show staff action until 12/24/2022, when it was noted that the pharmacy was contacted, and that the medication would be delivered on the evening of 12/24/2022. This document supported that facility staff were aware the medication (Coumadin) was not available from 12/21/2022 but did not take specific action to remedy this issue until 12/24/2022.

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, Spring Ridge Retirement, LLC is or will be in compliance with this law and / or regulation on (Date) 7/24/23.

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

Administrator (or Representative) — Date: 7/24/23