



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) 52115 (Completion Date 12/20/2024) and 46775 (Completion Date 10/28/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/20/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.090.2, RCW 70.129.140.1, RCW 70.129.140.4, WAC 388-78A-2660-1

The Department staff who did the on-site verification:
Kathy Heinz, Long Term Care Surveyor

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

Sincerely,

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

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



Residential Care Services Investigation Summary Report

Provider/Facility: Spring Ridge Retirement, LLC
License/Cert. #: 2160
Compliance Determination #: 46775
Investigator: Kathy Heinz
Investigation Date(s): 09/05/2024 through 10/28/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility
Intake ID: 140254
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

Bed bugs were alleged to be in the Identified Resident's (IR) room. The IR was told they could not leave their room. Facility staff threw away the IR's couch.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Dining Activities
Interviews:	Identified resident Family members Residents pest control company technician
Record Reviews:	care plans progress notes pest control paperwork policies and procedures

Investigation Summary:

Bed bugs were confirmed in IR's apartment and the facility staff told IR they could not have visitors and had to take their meals in their apartment. Based on interview and record review, the facility failed to ensure the rights of 2 of 2 residents were protected and a citation was written under 388-78A-2660 and RCW 70.129. The facility attempted to replace the couch by making an appointment with a local case management agency that would have given IR the referral needed to secure a couch from a local furniture bank. IR canceled the appointment with a local case management agency.

Conclusion / Action:

- ☒ 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 #: 2160	Compliance Determination # 46775
Plan of Correction	Spring Ridge Retirement, LLC	Completion Date
Page 1 of 4	Licensee: Spring Ridge Retirement, LLC	10/28/2024

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 09/05/2024 and 09/09/2024 of:

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

This document references the following complaint number(s): 140254

The following sample was selected for review during the unannounced on-site visit: 4 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Kathy Heinz, Long Term Care Surveyor

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

10/30/2024

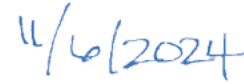
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

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



Administrator (or Representative)



Date

RCW 70.129.090 Advocacy, access, and visitation rights.

(2) The facility must provide reasonable access to a resident by his or her representative or an entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(4) A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure 2 of 2 Residents' (Resident 1 [R1] and Resident 2 [R2]) rights were protected when bed bugs were found in their apartments. This failure resulted in a loss of dignity and a sense of isolation for the residents.

Findings included...

Review of a facility policy (no date) titled, "Operations Policy- Manner in which the Community Operates," showed: It is the policy of this community to ensure compliance with all applicable state and federal regulations as specified in WAC 388-78A-2600. (WAC 388-78A-2600 (1)(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." RCW 70.129.140 (4) "A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility."

Resident 1

Review of R1's progress notes showed the following:

- 07/20/2024 R1's room was infested with bed bugs. R1 was told she would have to stay in her room and could not have visitors.
- 07/22/2024 R1 called staff and said she doesn't think she has bed bugs and wants to come out of isolation.

- 07/23/2024 R1 told a caregiver she felt like she was being "picked on" due to her age.
 - 07/24/2024 Staff document R1 was not able to leave her room and "join the others" for dinner because her room had bed bugs.
 - 07/25/2024 staff placed a tray of food outside R1's door and opened the door and let R1 know the tray was outside of her door.
 - 07/28/2024 R1 was moved to a new apartment.
- R1 was asked to stay in her apartment, was told she could not have visitors and not come out for meals for a total of 7 days.

During interviews on 09/05/2024 at 2:00 PM, 09/11/2024 at 12:50 PM and on 09/26/2024 at 12:36 PM, R1 said she felt ashamed and isolated when she was told to stay in her apartment. R1 said some of the staff left the food at the door and would not come in her apartment.

Resident 2

Review of R2's progress notes showed the following:

- 07/20/2024 R2's apartment was noted to have bed bugs. R2 was informed he could not leave his apartment, have visitors and his meals would be brought to him.
 - 07/21/2024 R2 was sitting in the doorway of his apartment. R2 was reminded of the risk of having the door open. R2 was upset that he was "trapped" in his room.
 - 07/22/2024 R2 was in the hallway and wanted someone to talk to. R2 explained to staff he doesn't have any bites.
 - 07/23/2024 R2 did not come out of his room and "was not happy."
 - 07/26/2024 R2 was moved to a new room.
- R2 was asked to stay in his apartment for a total 6 days.

R2 said during an interview on 09/26/2024 at 2:47 PM, he was told he could not come out of his room, and staff put a sign on his door that said, "do not enter." Sometimes staff did not tell him when his food tray was placed at his door.

Staff A, Executive Director was interviewed on 10/11/2024 at 3:30 PM. Staff A said she was advised to move the residents to a new room closer to the date when R1's and R2's rooms would be treated.

Plan/Attestation Statement

Statement of Deficiencies

License #: 2160

Compliance Determination # 46775

Plan of Correction

Spring Ridge Retirement, LLC

Completion Date

Page 4 of 4

Licensee: Spring Ridge Retirement, LLC

10/28/2024

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) 11/30/2024

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



Administrator (or Representative)



Date

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