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) 48207 (Completion Date 10/03/2024) and 39424 (Completion Date 06/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/03/2024 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:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2210-1-b, WAC 388-78A-2610-1, WAC 388-78A-2610-2-a

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

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: 114207
Compliance Determination #: 39424
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 04/08/2024 through 06/12/2024
Complainant Contact Date(s): 06/13/2024

Allegation(s):
1. Resident overmedicated

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Staff Resident representatives
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Medication administration records (MAR) Staff records Staff progress notes Medical records (After Visit Summary, Physicians' orders and communication) Incident log / reports, Facility P & P- Infection control, Medication management

Investigation Summary:
Per record review, interviews with residents' representatives, and staff, the facility failed to investigate medication errors or ensure safe medication practices for residents. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 06/12/2024.

Conclusion / Action:

- [x] 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: Spring Ridge Retirement, LLC
License/Cert.#: 2160
Compliance Determination #: 39424
Investigator: Carol Gijima
Investigation Date(s): 04/08/2024 through 06/12/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 123992
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Residents had respiratory illness

Investigation Methods:

Sample:	Total residents: Resident sample size: 5 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Staff Resident representatives
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named residents Medication administration records (MAR) Staff progress notes Medical records (lab reports, H & P summary) Incident log / reports Facility P & P- Infection control. Medication management

Investigation Summary:
Per record review and interviews with staff, the facility failed to investigate the causes of a respiratory outbreak or manage the spread of infection. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 06/12/2024.

Conclusion / Action:

- [x] 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 04/08/2024 and 04/08/2024 of:

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

This document references the following complaint number(s): 123992, 114207

The following sample was selected for review during the unannounced on-site visit: 5 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

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

06/26/2024
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.

Administrator (or Representative) 7/3/2024 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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate, determine causes, and to institute interventions to prevent recurrence for 1 of 5 Residents (Resident 1) who had an incident affecting their health. This placed Resident 1 at risk for ongoing medication errors, medical complications from not receiving medications correctly, and decreased quality of life.

Findings included..

Record review of a facility policy, titled, "Reporting Incidences", undated, showed, "This community will investigate all unexplained incidences and accidents that involve injury to residents. An internal investigation will be conducted, a thorough internal investigation will be conducted. Thorough documentation will be completed of the investigation and the resident and/or residents will be protected. Incident Report—An incident report will be prepared for any incident or accident involving a resident to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations." The policy showed under the documentation section, "Document on the incident report the date and time individuals were notified and the relationship of those individuals to the resident. The staff will document on the incident report the actions related to the incident. The service plan may be amended to include preventative measures to assure safety...The administrator or designee will review the incident report to determine if appropriate action has been taken and if additional actions are required including staff education, training, or discipline is require and to ensure that the negotiated services contract is updated...The administrator and/or designee will be available to assist the department and provide all pertinent investigation material as required for an investigation."

Resident 1 (R1)
During an interview on 03/28/2024 at 1:26pm, R1's Representative (RR1) stated that R1 had urgent care services called for a bladder infection and was supposed to be prescribed antibiotics. RR1 stated she was present during the visit, and nothing was mentioned about

changing any of R1's other medications. RR1 stated that she noticed that R1 was drowsier, was not participating in her usual routine and appeared "drugged out of her mind." RR1 stated that when she discovered there had been an error causing an increase in Seroquel (mental health medication), she notified facility staff, but they would not listen to her. RR1 stated that she questioned staff as to why there would be an increase in Seroquel when she was seen for a bladder infection, but facility staff started to refuse to speak to her. RR1 stated they refused to verify the new order with R1's primary provider even though the primary provider was the one who had initially prescribed the Seroquel.

Record review of an email sent to RR1 from the facility, dated 01/03/2024, showed Staff B, Registered Nurse, was aware of R1 receiving incorrect medication dosage for Seroquel following their urgent care visit, and was working to address it.

Review of R1's progress note, dated 01/03/2024 at 3:19am, showed that R1 was "confused about what time it is and what day it is…opens her door and asks if anyone is there…has not slept."

Review of R1's progress note, dated 01/03/2024 at 6:56pm, showed that the urgent care provider did not order any medication changes except for the bladder infection. The note showed the medications were reconciled incorrectly.

Review of facility fax to R1's primary care provider (PCP), dated 01/12/2024, showed that on 01/12/2024 R1's PCP was notified via fax of "another error."

During an interview on 05/31/2024 at 9:58am, Staff B stated that she conducted investigations if she was in the building or if notified about an incident. When asked if R1's increase in Seroquel error had been investigated, Staff B stated it had not. When asked why it was not investigated, Staff B stated, "I couldn't speak to that." Staff B stated that she was not initially notified about the error until R1 had an increase in behaviors and confusion.

During an interview on 04/08/2024 at 10:45am, Staff A, Administrator, was asked about the findings of the medication errors, Staff A stated they "haven't looked at medications as I should," and that they had "obviously investigated them." Staff A was not able to provide information on the investigative findings as they "review but do not sign off on them."

This is a recurring deficiency previously cited on 10/23/2023 and 05/01/2023.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2160	Compliance Determination # 39424
Plan of Correction	Spring Ridge Retirement, LLC	Completion Date
Page 4 of 8	Licensee: Spring Ridge Retirement, LLC	06/12/2024

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) ~~8/9/2024~~ 7/27/2024 gmd

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

Administrator (or Representative) — Date: 7/5/2024

WAC 388-78A-2210 Medication services.

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

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

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure that safe medication practices were in place when residents were not given medications as ordered, had orders discontinued without doctor orders and when there was an unauthorized increase in medication for 5 of 5 sample residents (Resident 1, 2, 3, 4 & 5 [R1, 2, 3, 4, & 5]). This failure resulted in Resident 1 being over-medicated, having decreased cognitive function and at risk for dehydration (loss of body fluids), and Residents 2, 3, 4, & 5 at risk for negative health outcomes.

Findings included...

Review of the ALF's medication policy undated showed that "the FIRST CHECK is done by initialing the order and dating it and placing it in the folder for the RCM (Residential Care Manager) to do the SECOND CHECK."

Record review on 04/08/2024 of R1's documents showed that R1 was admitted to the ALF on [redacted]/2023 with diagnoses to include [redacted]. Records showed that on 12/27/2023, R1 was seen by an urgent care medical provider and was diagnosed with a [redacted], [redacted] ([redacted]). The after-visit summary showed new orders for Milk of Magnesia to be taken daily (medication for constipation) and Seroquel 25mg twice a day (mental health medication). Previous orders were Seroquel 12.5mg at bedtime, and Milk of magnesia 30ml daily as needed for no bowel movement or if R1 complained of constipation.

Review of the December 2023 Medication Administration Record (MAR) showed the following:

Seroquel 12.5mg at bedtime was discontinued on 12/28/2023, and a new order for Seroquel 25mg twice a day started 12/27/2023. The MAR showed that R1 received Seroquel 25 mg twice a day on the 28th and 29th; that R1 refused the morning dose on the 31st but was given the evening dose. R1 refused the evening dose on the 30th.

Milk of magnesia was given on the following days 28, 29 and 30.

January 2024 MAR showed the following:

The morning Seroquel 25mg dose was administered on the 2nd and evening dose on the 3rd. The MAR showed that R1 was sleeping for the morning dose on the 1st, refused the evening dose on the 1st & the 2nd, and refused the morning dose on the 3rd.

Milk of Magnesia was given every day (except the 3rd) until it was held starting the 13th because R1 was having diarrhea. Medication was held until it was discontinued on 01/20/2024.

Review of R1's progress notes on 06/03/2024 showed that R1 refused to take the new medications and complained that it “makes her feel funny” and that her representative had instructed her not to take the Seroquel. A progress note on 01/03/2024 at 3:19am showed that R1 was “confused about what time it is and what day it is…opens her door and asks if anyone is there…has not slept.” A progress note on 01/03/2024 at 6:56pm showed that the urgent care provider did not order any medication changes except for the bladder infection and previous orders were reinstated. A progress note on 01/12/2024 showed that R1 had a new order for Milk of Magnesia and Loperamide daily. Review of facility documents showed that on 01/12/2024 R1’s primary provider was notified via fax of “another error.”

There was no facility documentation to show that these new orders were verified by any staff before being administered to R1.

Review of facility records on 05/29/2024 showed the following:

On 01/11/2024 R2 did not receive the 8am and 12pm dose of Novolog 100unit/ml insulin (blood sugar medication). Records showed that Novolog 100unit/ml insulin was “accidentally discontinued” by staff.

R3 did not receive his blood pressure medication, Hydralazine 100mg for two days, 01/13/2024 and 01/14/2024. Records showed that the medication was “accidentally discontinued” by staff on 01/12/2024.

R4 was given a sleeping medication when it was not scheduled on 03/17/2024 (Zolpidem 10mg). R4 was given the wrong dose of Lantus insulin (high blood sugar medication) injection on 03/28/2024. R4 received 29 units of Lantus instead of 23 units.

R5 did not receive her mental health medication for seven days (Risperdal 0.5mg) from 03/01/2024 to 03/17/2024.

During an interview on 03/28/2024 at 1:26pm, R1's Representative (RR1) stated that the mobile urgent care was called because R1 was suspected of having a bladder infection. RR1 stated that she notified staff on the increase in Seroquel, but staff refused to listen to her stating that R1 could make her own decisions and that they had an order. RR1 stated that they continued to give R1 the increased dosage resulting in her being overmedicated, drowsy, and not participating in her normal routine.

During an interview on 04/04/2024 at 2:55pm, R4's Representative (RR4) stated that R4 had an insulin overdose. RR4 stated that the medication technician called and notified her that R4 had been given too much insulin. RR4 stated she was not informed of the reason why she was given more insulin than prescribed.

During an interview on 04/08/2024 at 10:45am, Staff A, Administrator was asked about the process for medication errors. Administrator stated, "I don't know what their internal process is. I am not a med tech." When asked if administrator did not know what the staff were expected to do if there was a medication error, Staff A stated they would need to look it up but couldn't get into the system. In a separate interview on 06/04/2024 at 3:03pm, Staff A was asked what training medication technicians were provided to ensure safe medication practices. Staff A stated that they were not involved in the process, and that it was Staff B's (Registered Nurse) role. Staff A stated they reviewed medication error reports but would have limited information on the causes of the errors because they "wouldn't understand the narrative." When asked what the process was for verifying that residents' medications were accurate. Staff A stated that they did not question orders, that they "take the order and submit and give it." Staff A was asked what safe practices were in place to ensure residents were not administered wrong doses, Staff A stated, "if it was blurringly obvious we would question it."

During an interview on 05/31/2024 at 9:58am Staff B was asked what the process was to ensure accuracy when there was a medication change, Staff B stated that the medication technicians were supposed to notify her. When asked if she was notified of the increase in Seroquel, Staff B stated she was not, that the medication technicians saw the dosage change in the computer, verified that they had the medication on hand and "began administration." Staff B stated that medication technicians "know to reach out to the nurse delegator or nurse at facility" for significant changes. Staff B was asked what the facility process was to ensure safe medication administration. Staff B stated medication technicians were trained and delegated to pass medications. Staff B was asked what caused the same staff member to have medication errors for R2 and R3, one after the other. Staff B stated errors were accidents. Staff B stated she wasn't sure how the medication errors happened and that the staff involved was a new medication technician. When asked if the

staff was trained on medication management, Staff B stated they were.

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, Spring Ridge Retirement, LLC is or will be in compliance with this law and / or regulation on (Date) ~~8/9/2024~~ 7/27/2024

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

Administrator (or Representative) — Date: 7/5/2024

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to determine the source of a respiratory illness outbreak, manage the outbreak to prevent infection spread or ensure that staff were following infection control practices for 6 of 6 sampled residents (Resident 6, 7, 8, 9, 10, & 11 [R6, 7, 8, 9, 10, & 11]). This failure resulted in one resident (Resident 6) being hospitalized and placed all 26 residents at risk for negative health outcomes.

Findings included...

Record review of the department's records showed that the ALF had a resident who exhibited respiratory symptoms starting 03/12/2024 and was sent out to the hospital where the resident was diagnosed with Respiratory Syncytial Virus (RSV), a highly contagious virus. In the following days, six other residents had similar symptoms. There was no investigation on file to review.

During an interview on 05/31/2024 at 9:58am, Staff B, Registered Nurse stated that residents started with respiratory symptoms, and one ended up being hospitalized for RSV. Staff B was asked if there was any management of the outbreak, Staff B stated that they thought it was a cold. Staff B was asked if outbreak testing was done to rule out other

Statement of Deficiencies	License #: 2160	Compliance Determination # 39424
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infectious illnesses and determine that it was a cold, Staff B stated that it was not done. Staff B did not provide information on how the facility made the determination residents had a common cold. When asked what the investigation found to be the source of the infection, Staff B stated that they did not know. When asked if an investigation was done, Staff B stated, "not by me." Staff B was asked who was responsible for the investigation and prevention of illness spread, Staff B stated, "I don't know, maybe the RCC" (Resident Care Coordinator). Staff B stated that they were not present in the building every day.

During an interview on 04/08/2024 at 10:25am, Staff C, Resident Care Coordinator was asked what the process was for suspected infectious illness. Staff C stated that they obtained vitals of affected residents, notify the Registered Nurse (Staff B), providers and place the residents on alert. When asked if the outbreak would be investigated, Staff C stated that they didn't know if it would be investigated. Staff was asked how the facility managed the spread of the infection; Staff C stated they did "extra cleaning." When asked if affected residents were isolated, Staff C stated they were not because it was a common cold. Staff C stated that they would notify the Registered Nurse and the Resident Care Manager if there was a respiratory illness but didn't know if they investigated it.

During an interview on 04/08/2024 at 10:45am, Staff A, Administrator was asked about the facility's infection control process. Staff A stated that they used "UV (Ultraviolet) air purified in common areas." In an email dated 05/29/2024, Staff A stated that they did not have any infection investigations. In a separate interview on 05/31/2024 at 11:34am, Staff A was asked what their infection control policy was when there was an outbreak of an infectious illness, Staff A stated that they would have to "pull out the policy" and "I don't have time." When asked how they determined it was a common cold, ensured that the illness didn't spread, and if they isolated residents or ensured that staff followed infection control policies, Staff A stated, "I don't know what we could have done differently. It was a common cold and that's what we documented."

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, Spring Ridge Retirement, LLC is or will be in compliance with this law and / or regulation on (Date) 8/9/2024 7/27/2024

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

Administrator (or Representative) 7/5/2024 Date