STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

04/30/2024

SCRIBER GARDENS LLC

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

RE: SCRIBER GARDENS LLC License # 2203

Dear Administrator:

This letter addresses Compliance Determination(s) 40263 (Completion Date 04/24/2024) and 36493 (Completion Date 02/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/24/2024 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-2300-2-a-ii, WAC 388-78A-2240, WAC 388-78A-2230-1-c, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2371, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1

The Department staff who did the on-site verification:
Christine Banta, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 2203	Compliance Determination # 36493
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 1 of 12	Licensee: SCRIBER GARDENS LLC	02/07/2024

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 the unannounced on-site full inspection on 02/05/2024, 02/06/2024, 02/07/2024 and 02/07/2024 of:
SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

The following sample was selected for review during the unannounced on-site visit: 7 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Christine Banta, ALF Licensor
Jodi Condyles, ALF Licensor
Cristina Gonzalez, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

02/21/2024
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.

Betsy Frankie
Administrator (or Representative)

2-23-24
Date

WAC 388-78A-2300 Food and nutrition services.

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(ii) Approved by a dietitian; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to serve resident meals that had been reviewed and approved by a dietitian for 8 of 8 weekly menus reviewed. This failure resulted in 42 residents not receiving nutritionally balanced meals.

On 02/05/2024 and 02/07/2024 the food services menu dated 02/04/2024-02/11/2024 was observed posted at the main entrance of the facility and posted on the refrigerator in the main kitchen all menus failed to have a dietitian's signature.

On 02/05/2024 at 10:14 AM at Staff A, Executive Director, provided the food services menu dated 02/04/2024 -02/11/2024. The menu failed to have a dietitian's signature.

The food services menus dated 01/21/2024-02/10/2024 provided to Resident 3 failed to have a dietitian's signature.

The ALF's State Inspection binder provided at entrance had food services menus unsigned by a dietitian for the following dates: 10/01/2023-10/14/2023, 12/04/2023-12/30/2023, 01/07/2024 – 02/03/2024 and 02/04/2024-2/10/2024.

In an interview on 02/07/2024 at 11:51 AM, Staff H, Cook, stated that Staff G, Culinary Director, had been meeting with residents weekly to discuss food preferences then modified the food services menus based on information gathered. Staff H stated they were not aware a nutritionist needed to review and sign the menu prior to serving.

In an interview on 02/07/2024 at 12:22 PM, Staff A, stated that Staff G had been using a

seven-week rotating food menu which had been reviewed and approved by a dietitian. When Staff G modified the menu, it would be sent to the dietitian for review and signature. When the food services menu was returned it would be posted for residents.

In an interview on 02/07/2024 at 1:09 PM, Staff A stated they spoke to Staff G and learned no food service menus had been reviewed by a dietitian prior to residents receiving their meals.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) April 6th 2024

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

Betsy Frankie — Administrator (or Representative)

2-23-24 — Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain prescribed medications in a timely manner for 1 of 7 residents (Resident 3). This failure resulted in Resident 3 not having four prescribed medications available in a three month period and placed Residents 3 at risk for medical complications.

Findings included...

Review of the ALF's policy titled "Medication Services" dated 07/14/2022 showed staff will ensure availability of all prescribed orders when the ALF has assumed responsibility for obtaining them.

Resident 3 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] ([redacted]), [redacted] ([redacted]), and [redacted] ([redacted]).

Review of a signed family assistance with medication plan dated 01/03/2022 showed Resident 3's representative assumed responsibility for providing to the ALF all medications for Resident 3 and the ALF would maintain a minimum of three days of medications at the ALF. The medication plan showed that Resident 3's representative agreed to authorize the ALF to purchase any necessary medications should the required supply not be at the ALF.

Review of an assessment dated 07/07/2023 showed Resident 3's family would deliver medications to the ALF for the med techs to administer. The assessment showed if Resident 3's family was unable to deliver medications to the ALF, the medications would be ordered by the ALF through the ALF's pharmacy.

Review of an Electronic Medical Administration Record (EMAR) dated November 2023 showed Resident 3 was prescribed Vitamin D3 (a vitamin that helps the body absorb needed nutrients) one time daily. The EMAR showed Vitamin D3 was marked as not given from 11/30/2023 to 12/03/2023 (four doses) stating "refill requested" as the reason the medication was not given.

Review of an EMAR dated December 2023 showed Resident 3 was prescribed Nystatin powder (a medicated powder used to treat fungal infections of the skin) two times daily. The EMAR showed the Nystatin powder was marked as not given from 12/04/2023 to 12/08/2023 (eight doses) stating "refill requested" as the reason the medication was not given.

Review of an EMAR dated December 2023 showed Resident 3 was prescribed a Fluticasone and Salmeterol inhaler (a medication used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma) two times daily. The EMAR showed the inhaler was marked as not given from 12/26/2023 to 01/03/2024 (17 doses) stating "refill requested" as the reason the medication was not given.

Review of an EMAR dated January 2024 showed Resident 3 was prescribed Glipizide (a medication used to help control blood sugar levels for people with diabetes) once daily. The EMAR showed Glipizide was marked as not given on 01/11/2024 to 01/17/2024, 01/19/2024, 01/20/2024, and 01/23/2024 (10 doses) stating "refill requested" as the reason the medication was not given.

Review of an EMAR dated February 2024 showed Resident 3's twice daily Nystatin powder was marked as not given from 02/03/2024 to 02/05/2024 (five doses).

In an interview on 02/07/2024 at 11:27 AM, Staff A, Executive Director, stated that for residents with family assistance with medication delivery, medication supplies are to be looked through weekly to assess whether the family member of the resident needs to be called to reorder medications. Staff A stated that for these residents, if the medication is not available for ALF staff to give, staff are to order it through the ALF's pharmacy to ensure the resident receives their prescribed medications. Staff A stated that there shouldn't be gaps with medication administration due to medications not being available.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) April 16th 2024

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

Betsy Rankie — Administrator (or Representative)

2-23-24 — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the resident's physician for 1 of 7 residents (Resident 3) when Resident 3 chose not to take 51 doses of a prescribed medication in a three month period. This failure resulted in Resident 3's physician not being aware of the missed medications and placed Resident 3 at risk for not receiving informed decisions by their health care provider and complications related to untreated health care needs.

Findings included...

Review of the ALF's policy titled "Medications Administration" dated 07/22/2022 showed if a resident refuses medication, the resident's healthcare practitioner and the facility's Executive Director should be contacted and informed of the resident's decision.

Resident 3 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] ([redacted]).

Review of an assessment dated 07/07/2023 showed Resident 3 required staff to record and assist with all medications and to maintain and reorder all medications if the family is unable to do so. The assessment showed Resident 3 required licensed staff to confer with the pharmacy and doctor to oversee Resident 3's medication program.

Review of an electronic medication administration record (EMAR) dated November 2023 showed Resident 3 was to receive estradiol cream (a medicated cream used to help relieve certain symptoms of menopause) one time daily. The EMAR showed Resident 3 refused 12 of the 24 prescribed doses of estradiol in November.

Review of an EMAR dated December 2023 showed Resident 3 refused 21 of the 31 prescribed doses of estradiol in December.

Review of an EMAR dated January 2024 showed Resident 3 refused 22 of the 31 prescribed doses of estradiol in January.

Review of an EMAR dated February 2024 showed Resident 3 refused 1 of the 5 prescribed doses of estradiol in February.

In an interview on 02/07/2023 at 11:37 AM, Staff E, Resident Care Coordinator, stated that medication technicians were to attempt to give the medication three times in three different ways, and if the resident continued to refuse, the medication would be marked as refused, and their doctor would be faxed. Staff E stated that the fax to the doctor should let them know that their resident refused the day's dose and if it was a pattern. Staff were to request to see if changing the medication to 'as needed' or discontinued would be appropriate. Staff E stated that faxes to doctors would be in the resident's chart.

Review of Resident 3's medical records showed no physician fax notifications to show Resident 3's continued refusals of estradiol.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) April 6th 2024

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

Betsy Franklin — Administrator (or Representative)

2-23-24 — 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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to administer medications as prescribed when medications were entered into their electronic medication administration system (EMAR) inaccurately for 1 of 7 residents (Resident 3). This failure resulted in Medication Technicians (MTs) viewing inaccurate medication orders, Resident 3 not receiving medications as ordered, and placed Resident 3 at risk for medical complications related to medication errors.

Findings included...

Resident 3 was admitted to the ALF on [redacted]/2021 with multiple diagnoses including [redacted] ([redacted]).

Review of an assessment dated 07/07/2023 showed Resident 3 required licensed staff to "confer with the pharmacy and doctor to oversee Resident 3's medication program".

Review of a physician's order dated 06/07/2023 showed Resident 3 was prescribed Amoxicillin (an antibiotic used to treat bacterial infections) three times a day until gone for a total of 21 doses (approximately seven days).

Review of an EMAR dated November 2023 showed Resident 3's three times a day Amoxicillin was entered into the EMAR system on 06/08/2023 with a stop date of 11/06/2023 (a 151-day duration).

Review of a physician's order dated 02/16/2023 showed Resident 3 was prescribed estradiol cream (a medicated cream used to help relieve certain symptoms of menopause) daily for two weeks, off for one week, and repeat.

Review of a physician's order dated 08/31/2023 showed Resident 3 was prescribed Ketoconazole cream (a medicated cream used to treat skin infections caused by fungus) every day for 14 days.

Review of a physician's order dated 10/16/2023 showed Resident 3 was prescribed Benzonatate (a medication used to relieve coughing) as needed for seven days.

Review of a physician's order dated 06/07/2023 showed Resident 3 was prescribed Amoxicillin one hour prior to a dental appointment.

Review of a physician's quarterly medication review dated 11/13/2023 showed Resident 3's physician discontinued Resident 3's Benzonatate and Milk of Magnesia (a medication used to treat constipation) on 11/13/2023.

Review of Resident 3's EMAR dated February 2024 showed:

Estradiol cream was entered into the EMAR system as every day at 8:00 AM without rotations as prescribed.

Ketoconazole cream was entered into the EMAR system as every day at 8:00 AM with no stop date.

Amoxicillin was entered into the EMAR system as an as needed order to be used "one hour prior to appointment". The February 2024 EMAR showed Resident 3's Amoxicillin as an active order.

Benzonatate was entered into the EMAR system without a stop date. The February 2024 EMAR showed Benzonatate as an active order.

Milk of Magnesia was an active order.

In an interview on 02/07/2024 at 11:27 PM, Staff B, Wellness Director, stated that new orders were sent to their pharmacy where pharmacy staff would transcribe the order into the ALF's orders page. Staff B stated that a nurse from the ALF should double check if what was entered in by the pharmacy was accurate to the doctor's order. Staff B stated that if the order was accurate, the nurse would approve the order and it would then show up in the EMAR correctly for staff to view.

Plan/Attestation Statement

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

Betsy Rankie
Administrator (or Representative)

2-23-24
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 interview and record review, the Assisted Living Facility (ALF) failed to have a thorough investigation when 1 of 2 residents (Resident 4) was found injured on the floor. This failure resulted in the ALF not having a thorough investigation of Resident 4's injury and placed Resident 4's safety at risk.

Findings included...

Review of the Assisted Living Guidebook; Partners in Protection dated 02/2018, Chapter 2 and Appendix F showed State law requires the assisted living facility to do a thorough investigation when there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. For the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Review of the ALF's policy "Resident Falls/Accidents/Incidences" dated 09/06/2022 showed an incident report is started immediately to include phase one of their investigatory process. When the report is completed, it is to be submitted to the Wellness Director or the Executive Director. The Wellness Director or Executive Director is to evaluate results of the incidents and incorporate concepts learned into administrative decision-making aimed at preventing the recurrence of any substantiated event.

Resident 4 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

[redacted]), [redacted], and [redacted] ([redacted]).

Review of the incident report, dated 01/01/2024, showed Resident 4 was found crawling on the floor at 8:45 PM in the common area of the memory care unit. The incident report did not indicate who found Resident 4 on the floor. The incident report showed the resident had pointed to their left leg when asked if they were in pain as they squeezed their knee. It was revealed that the resident had sustained a hip fracture. The incident report showed three questions was checked off: the resident had a form of dementia, was taking medication that can cause a fall, and that the area was well lit. There was no other information included that a thorough investigation was done. The incident report was reviewed and signed by Staff A, Executive Director, on 01/07/2024. There was no written investigation on the report.

Review of the progress notes from showed Resident 4 was found on the floor on 01/01/2024 and could not state what happened. The progress note dated 01/01/2024 showed the resident was unable to bear weight and was transported to the hospital. The progress note dated 01/03/2024 showed Resident 4's spouse had called to inform them that the resident sustained a hip fracture and had undergone surgery.

On 02/07/2024 at 10:50 AM, Staff A stated that the nurse that knew more about the incident no longer worked for the building but still worked for the company. Staff A stated that they were going to call them.

On 02/07/2024 at 11:45 AM, Staff A stated that they had updated the incident report from 01/01/2024.

Review of the revised 01/01/2023 incident report showed a follow up paragraph was added and signed on 02/07/2024.

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) April 6th 2024

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

Betsy Faikis
Administrator (or Representative)

2-23-24
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to make a report to the Complaint Resolution Unit (CRU) hotline when 1 of 2 residents (Resident 4) had an unwitnessed incident resulting in a fractured hip. This failure resulted in an unreported significant injury incident and placed Resident 4 at risk for harm.

Findings included...

Review of the Assisted Living Facility Guidebook Partners in Protection, dated February 2018, contains guidelines intended to assist facilities in developing and implementing policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. On page 11, the guidebook showed that substantial injuries of unknown source not related to suspected abuse or neglect (because under some circumstances the failure to take preventive measures may constitute abuse or neglect) should be reported to the department immediately. The guidebook covers individual mandated reporting requirements on chapter 3 and reporting guidelines for assisted living facilities in Appendix D.

Review of the ALF's Corporate Incident Reporting Policy, dated 07/14/2022, showed all falls resulting in injury and/or hospitalization would be reported to the Executive Director by the Wellness Director, followed up with written documentation within three days of the occurrence. The ED would then immediately report the above occurrences to the Corporate Director of Operations and the Corporate Director of Assisted Living, following up with the written detailed investigation within one week. There was no mention of notifying the State Department Hotline in this policy.

Resident 4 was admitted to the ALF on [redacted]/2023 with multiple diagnoses including [redacted].

Review of the progress notes from 11/07/2023 to 02/05/2024 showed Resident 4 was found on the floor 01/01/2024 and could not state what happened. Resident 4 was unable to bear weight and was sent to the hospital. On 01/03/2024, the ALF was notified that Resident 4 had a broken hip and had undergone surgery.

Review of the incident report, dated 01/01/2024, showed the Resident 4 was found crawling on the floor in the common area of the memory care unit. Resident 4 was able to communicate that they were in pain but was unable to say what happened. The incident report showed the State Department hotline was not called.

On 02/07/2024 at 10:45 AM, Staff A, Executive Director, stated that the nurse that had done the investigation was not available to answer questions and that they were going to call them to get a follow up.

On 02/07/2024 at 11:45 AM, Staff A stated that the incident report was updated after speaking with the nurse.

Review of the revised 01/01/2024 incident report showed that a follow up statement was added and signed on 02/07/204. The revised report still showed the State department was not notified of the incident.

Review of the department's Secure Tracking And Reporting System showed no report was made regarding the 01/01/2024 incident.

Plan/Attestation Statement

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

Betty Faulkner 2-23-24

Administrator (or Representative) Date