STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Highgate Wenatchee LP
HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

RE: HIGHGATE SENIOR LIVING License # 2225

Dear Administrator:

This letter addresses Compliance Determination(s) 41317 (Completion Date 05/15/2024) and 38792 (Completion Date 04/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/15/2024 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-2210-2-a

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 38792
Investigator: Brittney Shull
Investigation Date(s): 03/25/2024 through 04/09/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 122428
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The named staff member assisted with medications, did not ensure the residents swallowed them, and they were later found still in the medication cup.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Staff to resident interaction, Staff availability and responsiveness to resident needs, Medication Administration, Medication storage and supply.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Medication Administration Record (MAR), Facility Policies, Resident Records.

Investigation Summary:
Resident to staff interactions were observed to be appropriate and respectful. Interview showed that residents felt their needs were met and staff were responsive to their needs. Observation, interview, and record review showed that not all residents who required medication assistance had received all their medications as prescribed. Failed Practice Identified, WAC 388-78A-2210(2)(a) reference Statement of Deficiencies dated 04/09/2024.

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: HIGHGATE SENIOR LIVING
License/Cert.#: 2225
Compliance Determination #: 38792
Investigator: Brittney Shull
Investigation Date(s): 03/25/2024 through 04/09/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 123982
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The named resident has not been getting their medications and staff has been signing off that they have.

Investigation Methods:

Sample:	Total residents: 56 Resident sample size: 5 Closed records sample size: 0
Observations:	Environment, Staff to resident interaction, Staff availability and responsiveness to resident needs, Medication Administration, Medication storage and supply.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Medication Administration Record (MAR), Facility Policies, Resident Records.

Investigation Summary:
Resident to staff interactions were observed to be appropriate and respectful. Interview showed that residents felt their needs were met and staff were responsive to their needs. Observation, interview, and record review showed that not all residents who required medication assistance had received all their medications as prescribed. Failed Practice Identified, WAC 388-78A-2210(2)(a) reference Statement of Deficiencies dated 04/09/2024.

Conclusion / Action:

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

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2225	Compliance Determination # 38792
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 1 of 3	Licensee: Highgate Wenatchee LP	04/09/2024

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 03/25/2024 and 03/25/2024 of:

HIGHGATE SENIOR LIVING
1320 S MILLER ST
WENATCHEE, WA 98801

This document references the following complaint number(s): 122428, 123767, 123982

The following sample was selected for review during the unannounced on-site visit: 5 of 56 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

04/17/2024
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.

Statement of Deficiencies	License #: 2225	Compliance Determination # 38792
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 2 of 3	Licensee: Highgate Wenatchee LP	04/09/2024

Administrator (or Representative) 4/26/24 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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure that each resident who required medication assistance received their medications as prescribed for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 not receiving their Trazodone (a medication sleep aid) as ordered.

Findings included...

Record review of a facility policy titled, "Medication Policy," dated 09/2018, showed that the ALF would ensure that staff would be properly trained or delegated to deliver medications to each resident as ordered by the physician including following the Service Plan and witnessing residents take their medication.

Record review of the facility Negotiated Service Agreement (NSA) dated 12/13/2023 showed that Resident 1 received medication assistance and that the medication aide was to ensure they would take all their medications. It further showed that Resident 1 would often forget to take their medications if left to take them on their own.

Record review a facility Medication Administration Record (MAR) for March 2024, showed that 25 milligram (mg) Trazodone was given nightly from 03/01/2024-03/24/2024 for insomnia. It showed that the Trazodone was scheduled to be given between the hours of 6:00PM and 10:00PM.

In an observation and interview on 03/25/2024 at 2:52PM, Staff C, Medication Aide, prepared and handed a resident a cup full of medications at the entry way to their apartment. The resident took the cup from Staff C and closed the door. Staff C stated that the resident and another resident were the only residents that were allowed to be handed their medications without staff observing them swallow the medications. They further stated that the resident's NSA should indicate whether the medication aides needed to observe the resident taking their medications.

Statement of Deficiencies	License #: 2225	Compliance Determination # 38792
Plan of Correction	HIGHGATE SENIOR LIVING	Completion Date
Page 3 of 3	Licensee: Highgate Wenatchee LP	04/09/2024

In an interview on 03/25/2024 at 3:52PM, Staff C stated that Resident 1 should not have any medications stored in their room because Resident 1 had not been taking their Trazodone and had a stash of the pills found in their apartment.

In an interview on 03/27/2024, Collateral Contact 1 (CC1) stated that Resident 1 did not like taking the Trazodone at dinner time and preferred to take it closer to bed time, so they would tell staff they would take the Trazodone later but would forget to take it. They stated that in December of 2023, they found 7 Trazodone pills in Resident 1's apartment. CC1 handed the Trazodone pills to facility staff and told them that they believed this was the reason Resident 1 had an increase in agitated behaviors. CC1 then asked staff to either re-approach later in the evening or to call them and they would come to the ALF to help if Resident 1 refused to take their Trazodone. They stated that on 03/21/2024 Resident 1 was displaying behaviors again, so CC1 checked Resident 1's apartment and found more Trazodone pills.

In an interview on 03/28/2024 at 10:01AM, Staff A, Executive Director, stated that they were aware that there was a concern that Resident 1 had not been getting their medications. They stated staff should have followed their process and should not have left medications with Resident 1 to take when they wanted to.

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, HIGHGATE SENIOR LIVING is or will be in compliance with this law and / or regulation on (Date) 5/8/24 .

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

Administrator (or Representative) — Date: 4-26-24

WAC 388-78A-2210 Medication Services

a. On 5/1/24 a Medication Aide meeting will be held by the Health Care Director to review Highgate policy and procedure for passing medication including the need to witness residents taking their medications unless assessed otherwise.
b. Medication Aides not able to attend the meeting on 5/1/24 will meet with Health Care Director to review Highgate policy and procedure for passing medication including the need to witness residents taking their medications unless assessed otherwise.
c. Interviewed Manor residents to verify that Medication Aides are witnessing medication being taken when passing them for residents who need to be observed.
d. Health Care Director and/or ED will complete a random monthly audit to verify that medications being administered and are witnessed by the Medication Aide if required. If any issues are noted the Medication Aide will be formally counseled.
e. Resident 1 indicated to family and Highgate that he no longer wanted to take so many medications. Physician was informed and the bedtime medication was discontinued.