STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

CHP Longview-Monticello Park WA Tenant Corp
Prestige Senior Living Monticello Park
605 Broadway St
Longview, WA 98632

RE: Prestige Senior Living Monticello Park License # 2238

Dear Administrator:

This letter addresses Compliance Determination(s) 46719 (Completion Date 09/25/2024) and 42616 (Completion Date 07/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/25/2024 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-2350-1

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Prestige Senior Living Monticello Park
License/Cert.#: 2238
Compliance Determination #: 42616
Investigator: Jacob Ubl
Investigation Date(s): 06/11/2024 through 07/19/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 137400
Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Resident/patient/client neglect: Allegation that the facility failed to coordinate health care services.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Identified resident Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident staff Residents
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Resident/patient/client neglect: Failed practice identified. The facility failed to coordinate health care services.

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: Prestige Senior Living Monticello Park
License/Cert.#: 2238
Compliance Determination #: 42616
Investigator: Jacob Ubl
Investigation Date(s): 06/11/2024 through 07/19/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 134488
Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Quality of Care/ treatment: Allegation that the facility was not meeting a residents needs.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident staff Residents
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/ treatment: Failed practice identified. The facility failed to coordinate health care services.

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: Prestige Senior Living Monticello Park
License/Cert.#: 2238
Compliance Determination #: 42616
Investigator: Jacob Ubl
Investigation Date(s): 06/11/2024 through 07/19/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 132742
Region/Unit #: RCS Region 3 / Unit I

Allegation(s):

1. Quality of Care/ treatment: Allegation that the facility does not keep residents care plans up to date and fails to coordinate health care services.

2. Nursing Services: Allegation that the facility does not have a nurse delegator.

Investigation Methods:

Sample:	Total residents: 68 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/ treatment: Failed practice identified. The facility failed to coordinate health care services.

2. Nursing Services: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns.

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
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2238	Compliance Determination # 42616
Plan of Correction	Prestige Senior Living Monticello Park	Completion Date
Page 1 of 3	Licensee: CHP Longview-Monticello Park WA Tenant Corp	07/19/2024

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 06/11/2024 and 07/19/2024 of:

Prestige Senior Living Monticello Park
605 Broadway St
Longview, WA 98632

This document references the following complaint number(s): 133223, 131297, 132742, 133167, 134488, 134880, 137400

The following sample was selected for review during the unannounced on-site visit: 3 of 68 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

07/23/2024
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) 7/26/24 Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to coordinate care and services from an external provider and integrate external provider information into the Negotiated Service Agreement (NSA) for 1 of 6 sampled residents (Resident 1). This failure placed Resident 1 (R1) at risk for unmet care needs.

Findings included...

Review of an undated face sheet showed R1 was admitted to the facility on [redacted]/2021 and documented R1 had a diagnosis of [redacted].

Record review of R1's July 2024 Medication Administration Record (MAR) documented the medication Warfarin prevent blood clots) One MG (Milligram) tablet, "Give 1.5 tablet by mouth at bedtime".

In an interview on 07/09/2024 at 9:45 AM, Collateral Contact 1 (CC1), Nurse Practitioner and Primary Care Provider (PCP) for R1, reported that the facility was failing to communicate with them and their clinic, The Family Health Center (FHC), regarding R1's health care needs. R1 had Atrial Fibrillation and the facility was failing to coordinate R1's warfarin (a medication used for the prevention of blood clot formation) management with the FHC. CC1 reported that R1 was more than three weeks overdue for their last ordered "INR" blood draw (A blood test that measures the time it takes for blood to clot). CC1 reported that the failure to coordinate R1's INR test puts R1 at high risk of potential life-threatening complications from a blood clot with R1's INR test results not being known for over three weeks.

In an interview, during an unannounced visit, on 07/08/2024 at 12:39 PM, Staff A, Health Services Director (HSD), reported that R1 missed their most recent INR date that was ordered by R1's PCP, about three weeks prior. Staff A reported that the FHC did not have an appointment available for R1's ordered INR date, so she did not take the FHC's next available appointment, intending to coordinate getting R1's INR tested elsewhere, but failed to coordinate R1's INR test. Staff A didn't know the date when R1's last INR was done, the last INR tests result for R1, or the date when R1's INR was due, and that not knowing those answers was poor Warfarin management. Staff A reported that the facility failed to follow up after 06/12/2024 with the FHC regarding R1's INR testing, R1's potential Warfarin dosing changes, and scheduling R1's next INR. Staff A reported that it was unsafe that R1 was three weeks late on their INR draw.

Administrator (or Representative) Date

WAC 388-78A-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to coordinate care and services from an external provider and integrate external provider information into the Negotiated Service Agreement (NSA) for 1 of 6 sampled residents (Resident 1). This failure placed Resident 1 (R1) at risk for unmet care needs.

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In an interview on 07/08/2024 at 9:45 AM, Collateral Contact 1 (CC1), Nurse Practitioner and Primary Care Provider (PCP) for R1, reported that the facility was failing to communicate with them and their clinic, The Family Health Center (FHC), regarding R1's health care needs. R1 had Atrial Fibrillation and the facility was failing to coordinate R1's warfarin (a medication used for the prevention of blood clot formation) management with the FHC. CC1 reported that R1 was more than three weeks overdue for their last ordered "INR" blood draw (A blood test that measures the time it takes for blood to clot). CC1 reported that the failure to coordinate R1's INR test puts R1 at high risk of potential life-threatening complications from a blood clot with R1's INR test results not being known for over three weeks.

In an interview, during an unannounced visit, on 07/08/2024 at 12:39 PM, Staff A, Health Services Director (HSD), reported that R1 missed their most recent INR date that was ordered by R1's PCP, about three weeks prior. Staff A reported that the FHC did not have an appointment available for R1's ordered INR date, so she did not take the FHC's next available appointment, intending to coordinate getting R1's INR tested elsewhere, but failed to coordinate R1's INR test. Staff A didn't know the date when R1's last INR was done, the last INR tests result for R1, or the date when R1's INR was due, and that not knowing those answers was poor Warfarin management. Staff A reported that the facility failed to follow up after 06/12/2024 with the FHC regarding R1's INR testing, R1's potential Warfarin dosing changes, and scheduling R1's next INR. Staff A reported that it was unsafe that R1 was three weeks late on their INR draw.

Record review of R1's NSA, dated 06/06/2024, showed R1 was to "receive coordination of health services from the HSD/RSD as required by their diagnosis".

Record review of electronic messages between the FHC and the facility for R1, dated 06/12/2024, showed CC1 stated "As previously discussed, recheck INR 3 days after restarting Warfarin". The record did not show that the facility sent a message back to CC1 to follow up on CC1's instructions and further coordinate care.

The facility was unable to produce a record to show that the facility responded to or followed up on CC1's, 06/12/2024, instructions to further coordinate care for R1.

In an interview on 07/08/2024 at 1:27 PM, Staff B, Resident Care Coordinator (RCC), reported that R1 should have had their INR done about three weeks prior, as ordered by R1's PCP. Staff B reported that the facility not communicating further with the FHC after 06/12/2024 was inappropriate and that "It's a failure on our part for sure.".

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, Prestige Senior Living Monticello Park is/or will be in compliance with this law and / or regulation on (Date) 7/26/24 .

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

Administrator (or Representative) — Date 7/26/24

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

_____ _____

Administrator (or Representative) Date