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

Pacifica SL Ellensburg LLC
Pacifica Senior Living Ellensburg
818 E Mountain View Ave
Ellensburg, WA 98926

RE: Pacifica Senior Living Ellensburg License # 2376

Dear Administrator:

This letter addresses Compliance Determination(s) 42662 (Completion Date 06/17/2024) and 39000 (Completion Date 04/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/17/2024 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-2600-2-i, WAC 388-78A-2371-1, WAC 388-78A-2371-2

The Department staff who did the on-site verification:
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Pacifica Senior Living Ellensburg
License/Cert.#: 2376
Compliance Determination #: 39000
Investigator: Felicia Cantu
Investigation Date(s): 03/28/2024 through 04/25/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 124205
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):

1) A named resident had a non-reported fall that led to their death.
2) A named resident was left in their wheelchair undressed and unable to move in their wheel chair.
3) Care staff hide resident's medications in their drinks and are not delegated.
4) Resident medications are left out unattended.

Investigation Methods:

Sample:	Total residents: 70 Resident sample size: 5 Closed records sample size:
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration Fall prevention
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Incident investigations and staff schedules Resident records (face sheet, care plans, assessments, chart notes, doctor orders).

Investigation Summary:

1) Interviews and record review showed that the facility failed to follow their alert charting procedures for monitoring a resident after they returned from the hospital. Failed practice found WAC 388-78A-2600. Interviews and record review showed that the facility failed to document and investigate circumstances of an unwitnessed fall.

Failed practice identified
2) Observations showed that residents were able to move around the facility freely and were dressed and groomed. Staff to resident interactions appeared helpful and safe. Interviews and record review showed that their were not residents alleged to be restrained and are unable to move in their wheel chair. No failed practice identified. 3,4) Observations showed that their were no medications left out unattended, and residents were taking their medications as doctor prescribed. Interviews and record review showed that the named resident and their family were aware that they were taking their medications as prescribed. The facility was in process of initiating and implementing a nurse delegation program added to the services they provide. No failed practice identified.

Conclusion / Action:

- [x] 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 #: 2376	Compliance Determination # 39000
Plan of Correction	Pacifica Senior Living Ellensburg	Completion Date
Page 1 of 5	Licensee: Pacifica SL Ellensburg LLC	04/25/2024

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 03/28/2024 and 03/28/2024 of:

Pacifica Senior Living Ellensburg
818 E Mountain View Ave
Ellensburg, WA 98926

This document references the following complaint number(s): 124205, 122468

The following sample was selected for review during the unannounced on-site visit: 5 of 70 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, 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

05/02/2024 — 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) Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy and procedures for 1 of 2 residents (Resident 1) reviewed for alert charting. This failure placed the resident at risk of additional injuries and unmet care needs.

Findings included...

Review of the facility's policy "Alert Charting" dated 06/19/2021, showed that alert charting would be implemented for residents who need closer monitoring which included when a resident returned from the hospital, had fallen, or exhibited a change in the resident's expected or customary pattern in physical or mental function. The alert charting process included that care staff would be reminded through their in-service planning program. The Resident Care Director would assign alert charting responsibilities and monitor the alert charting daily. There was to be an alert charting entry in the resident record each shift. The Resident Care Director, Nurse, or designee would initiate the Health Alert form for each resident who required monitoring. Care staff would complete progress notes on the Health Alert form as applicable.

Record review showed that Resident 1 admitted to the facility on [redacted] 2022 with diagnosis of [redacted].

On 04/22/2024 at 10:30 AM, Collateral Contact 1 (CC1) stated that Resident 1 had two falls prior to Resident 1's passing on [redacted] 2024. Resident 1 was sent to the hospital after their initial fall on Thursday night [redacted] 2024. The resident returned to the facility and had a second fall "about eight hours later, it would have been on night shift". CC1 stated they were unsure if Resident 1 hit their head again because it was an unwitnessed fall. CC1 expressed that they declined another Emergency room visit after the second fall but did see a decline in Resident 1's health condition after the falls.

On 04/23/2024 at 1:33 PM Staff D, Caregiver stated that she had notified Staff E, Health

and Wellness Director when Resident 1 fell on her designated night shift on [redacted]/2024 (following the initial fall and hospitalization). Staff D expressed she was directed to "keep an eye" on Resident 1 but was not directed to initiate alert charting.

Record review of Resident 1's facility chart notes dated [redacted]/2024 - [redacted]/2024 showed that on [redacted]2024, Resident 1 was found on the floor with their face down on the ground and was sent to the hospital. Resident 1 returned to the facility the same day. The record did not show that Resident 1 had another reported fall the next morning. The record showed on [redacted]/2024 Resident 1 was placed on end-of-life care and passed away on [redacted]2024.

Review of Resident 1's record from [redacted]/2024 - [redacted]/2024 not show that alert charting was initiated after Resident 1 returned from the hospital to the facility on [redacted]/2024.

On 04/25/2024 at 9:40 AM, Staff G Resident Care Coordinator stated that they usually documented vitals in the facility's medication administration computer program when monitoring a resident was needed, Staff G stated they were unsure where the documentation for "alert charting" was to be documented.

On 04/25/2024 at 9:45 AM, Staff E stated that they could not find documentation that a temporary service plan or alert charting had been initiated following the resident's fall. Staff E stated that the facility could improve on their policy and procedures of directing staff on the alert charting process.

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, Pacifica Senior Living Ellensburg is or will be in compliance with this law and / or regulation on (Date) 5/27/2024.

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

Administrator (or Representative) — Date: 5/07/2024

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;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions to determine the circumstances of fall for 1 of 2 residents (Resident 1). This failure resulted in a lack of investigation and placed the resident at risk of harm.

Findings included...

Review of the facility's policy "Internal Incident report and State Incident Report" dated 12/09/2021 showed that staff will complete all unusual occurrences, injury, and incidents. State incident reports are completed if required by regulations. The facility must investigate and document investigative actions and findings for any accident or incident affecting a resident's health or life and determine the circumstances of the event.

Record review showed that Resident 1 admitted to the facility on [redacted]2022 with diagnosis of [redacted].

On 03/28/2024 at 11:35 AM, Staff A, Administrator stated that he was aware that Resident 1 fell one time on [redacted]/2024 and was not aware of a second fall.

On 03/28/2024 at 12:20 PM, Staff B, Caregiver stated that Resident 1 had a second fall on [redacted]2024, after they had returned to the facility from the hospital following the first fall on [redacted]/2024.

On 04/22/2024 at 10:30 AM Collateral Contact 1 (CC1) stated that Resident 1 had two falls prior to Resident 1's passing on [redacted]2024. Resident 1 was sent to the hospital after their initial fall on Thursday night [redacted]2024 and returned to the facility and had a second fall that was unwitnessed "about eight hours later, it would have been on night shift".

Review of Resident 1's incident report records from [redacted]/2024 – [redacted]/2024 did not show that Resident had a second fall on [redacted]/2024, the record did not contain an investigation to determine the circumstances of the fall or investigative actions or findings.

On 04/23/2024 at 11:24 AM Staff F, Caregiver stated that they found Resident 1 in their apartment on the floor on [redacted]/2024 early morning (second fall), and notified Staff G, Lead Medication Technician.

On 04/23/2024 at 12:06 PM, Staff G stated that she was notified of Resident1's second fall on [redacted]/2024 but could not find the incident report and was unsure if the incident was investigated.

On 04/23/2024 at 11:25 AM, Staff A stated that the facility normally documents their investigation reports as a narrative report either in the facility's progress notes or in a separate file.

On 04/25/2024 at 9:45 AM, Staff E, Health and Wellness Director stated that there was not

an investigative report on file.

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, Pacifica Senior Living Ellensburg is or will be in compliance with this law and / or regulation on (Date) 5/27/2024 .

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

Administrator (or Representative) 5/07/2024 Date