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

BFG Kennewick Master Tenant LLC
Ciel Senior Living of the Tri-Cities
7255 W Grandridge Blvd
Kennewick, WA 99336

RE: Ciel Senior Living of the Tri-Cities License # 2449

Dear Administrator:

This letter addresses Compliance Determination(s) 48446 (Completion Date 10/09/2024) and 45016 (Completion Date 08/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/09/2024 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-2090-6-e, WAC 388-78A-2140-1-a, WAC 388-78A-2140-1-a-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-1-a-iii, WAC 388-78A-2140-1-c, WAC 388-78A-2140-5, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2570

The Department staff who did the on-site verification:
Elaine Lopez, Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services

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

BFG Kennewick Master Tenant LLC
Ciel Senior Living of the Tri-Cities
7255 W Grandridge Blvd
Kennewick, WA 99336

RE: Ciel Senior Living of the Tri-Cities # 2449

Dear Administrator:

This document references the following complaint numbers 140458, 140554.

The Department completed a full inspection of your Assisted Living Facility on 08/13/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services

Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

The Assisted Living Facility failed to ensure a written plan for family assistance with medication was developed and included the required elements. The facility intended to develop a written plan.

WAC 388-78A-2680 Electronic monitoring equipment Audio monitoring and video monitoring.

(2) The assisted living facility may video monitor and video record activities in the facility or on the premises, without an audio component, only in the following areas:

(a) Entrances, exits, and elevators as long as the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather.

The Assisted Living Facility failed to ensure that electronic monitoring was not used in resident gathering areas. The facility management had a plan to adjust the monitoring device angles to ensure that electronic monitoring did not occur in resident gathering areas.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

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

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 and complaint investigation on 08/05/2024, 08/06/2024, 08/07/2024 and 08/08/2024 of:

Ciel Senior Living of the Tri-Cities
7255 W Grandridge Blvd
Kennewick, WA 99336

This document references the following complaint numbers: 140458, 140554.

The following sample was selected for review during the unannounced on-site visit: 10 of 78 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Elaine Lopez, Licensor
Robin Rainville, Assisted Living Facility Licensor
Tracy Ramirez, Assisted Living Facility Licensor
Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Elizabeth Hall, AFH/ALF Licensor

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.

Residential Care Services — 08/20/2024 (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.

Ashley Guido, RN
Signer ID: LUQJMEAH11
Administrator (or Representative) — 8/27/2024 (Date)

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including.

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to complete a full assessment addressing the required elements when residents required the use of medical devices for 2 of 2 residents (Residents 7 and 8). This failure placed the residents at of risk injury due to not being assessed for the use of devices that posed a danger.

Findings included...

^Resident 7>

In an interview on 08/07/2024 at 12:34 PM, Resident? stated that they had two transfer poles (a grab bar that extends from the floor to the ceiling and provides support with physical transfers) and did not recall if the ALF had assessed them to safely use the poles. Resident 7 stated that they used the transfer poles to get in and out of their bed and recliner. Observation at that time showed that there was one transfer pole located next to Resident 7's recliner and the other next to their bed.

Review of Resident 7's assessment, dated 05/16/2024, showed that the resident was unable to walk and required extensive assistance of two staff members when they were utilizing a transfer pole to transfer.

Review of Resident 7's Negotiated Service Agreement (NSA), dated 05/16/2024, listed transfer pole under Assistive/Adaptive Devices. The NSA showed that Resident 7 needed extensive assistance of two staff and the use of a transfer pole when transferring.

Review of an incident report, dated 06/29/2024, showed that Resident 7 had an unwitnessed fall and was found lodged between their bed and their transfer pole and sustained several skin tears.

Review of Resident 7's record showed no documentation of a transfer pole safety assessment.

In an interview on 08/08/2024 at 8:39 AM, Staff G, Registered Nurse/Campus Director of Nursing, stated that they had concerns regarding Resident 7's safe use of the transfer poles. Staff G stated the facility did not conduct an assessment of Resident 7's ability to use a transfer pole.

<Resident 8>

In an interview on 08/07/2024 at 1:58 PM, Resident 8 stated that they had two transfer poles. Resident 8 stated that the ALF did not assess them for the safety of the transfer poles. Observation at that time showed that there was one transfer pole located next to Resident 8's recliner and the other next to their bed.

Review of Resident 8's Assessment, dated 07/30/2024, showed that the resident had a transfer pole. Resident 8's assessment showed that they required extensive assistance for mobility. The assessment did not show that the ALF had performed a safety assessment for Resident 8's transfer poles.

Review of Resident 8's NSA, dated 07/30/2024, showed that they had diagnoses of [redacted], and [redacted]. The NSA showed that Resident 8 had a transfer pole.

In an interview on 08/08/2024 at 1:05 PM, Staff G stated that they did not have transfer pole assessments for the residents. Staff G stated that they were not aware of the requirement to assess a resident's ability to use a transfer pole.

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, Ciel Senior Living of the Tri-Cities is or will be in compliance with this law and / or regulation on (Date) 9/27/2024

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

Ashley Guido, RN
Signer ID: LUOJMEAH11
Administrator (or Representative)

8/27/2024
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(i) The resident's preadmission assessment;

(ii) The resident's full assessments;

(iii) On-going assessments of the resident.

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to develop and document in the resident's record, the plan to meet individual residents' assessed needs which imposed risks to their health and safety, for 4 of 10 residents (Resident 3, 4, 5, and 7). This failure placed residents at risk of harm from needs not being met.

Findings included...

<Resident 3>

Review of Resident 3's facility assessment, dated 04/01/2024, showed that the resident had heart problems and had a cardiac pacemaker (a surgically implanted device that regulates the heartbeat). The assessment showed that Resident 3 required medication assistance and required nurse delegation (a trained medication technician to administer certain medications and treatments).

Review of Resident 3's Negotiated Service Agreement (NSA), dated 04/01/2024, showed that the resident's pacemaker was not identified. The NSA did not show how the device was monitored and who to contact about the device in the event of malfunction. The document did not show that Resident 3 required nurse delegation for medications that they received.

In an interview on 08/05/2024 at 2:10 PM, Resident 3 stated that they had a pacemaker. The resident stated that they left their pacemaker monitoring device at a previous residence and that they did not have it at the ALF.

<Resident 4>

Review of Resident 4's assessment, dated 06/14/2024, showed that the resident had diagnoses of [redacted] and [redacted]. Additionally, Resident 4's assessment showed that they had a pacemaker, required occupational therapy, took an anti-depressant medication, and had difficulty using the call system.

Review of Resident 4's June 2024-August 2024 medication administration records (MARs) showed that the resident took a medication for depression.

In an interview on 08/08/2024 at 1:02 PM Staff G, Registered Nurse/Campus Director of Nursing, stated that Resident 4 shared a call light pendant with their spouse and received occupational therapy.

Review of Resident 4's NSA, dated 06/14/2024, showed that it did not include who was to monitor the resident's pacemaker and how, what to monitor for and what the risks were with their diagnoses of [redacted] and their anti-depressant medication. Additionally, Resident 4's NSA did not document that the resident required occupational therapy or address their difficulty in using the call system.

<Resident 5>

Review of Resident 5's assessment, dated 04/16/2024, showed that the resident had a diagnosis of [redacted] and [redacted]. Resident 5's assessment showed that the resident self-administered their medications and did their blood sugar monitoring independently.

Review of Resident 5's NSA, dated 04/16/2024, showed it did not include that the resident was independent with their medications and blood sugar monitoring. Resident 5's NSA did not document that the resident had weakness in their left arm, that they had an unsteady gait, or that they received physical therapy.

<Resident 7>

Review of Resident 7's assessment, dated 05/16/2024, showed that they had a diagnosis of a [redacted] and that they had a urinary catheter (a tube coming out of the bladder to drain urine from the body into an external collection bag} which staff were to empty each shift. The assessment showed that a third-party provider was required for support in the care of Resident 7's catheter.

Review of a progress note in Resident 7's record, dated 06/19/2024, showed that Resident 7's catheter was a suprapubic type (the tube drained urine through a cut made through the abdomen, rather than inserted into the urethra). The note showed that the insertion site was red.

Review of a progress note, dated 07/03/2024, showed that Resident 7's catheter tube had caused a blood blister on their leg. The note showed that the resident was not to use the leg strap fortheir catheter tube, which was what caused the blister.

Review of an outside provider visit note, dated 07/17/2024, showed that the catheter insertion site had developed a moderate amount of drainage that might require further medical intervention. Review of another outside provider note, dated 07/31/2024, showed that the insertion site was bleeding and had dried blood all around the site.

Review of Resident 7's NSA, dated 05/16/2024, showed that the resident had a catheter that staff were to empty each shift. The NSA did not specify what type of catheter Resident 7 had, or what staff were to monitor at the insertion site. The NSA did not identify who provided the third-party support for Resident 7's catheter.

In an interview on 08/08/2024 at 0:27 AM, Staff G stated that catheter care, monitoring, and intervention information for Resident 7, was not on their NSA.

Phn/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, Ciell Senior Living of the Tn-Cities is or will be in compliance with this law and/or regulation on (Date) 9/27/2024 .

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

Ashley Guido, RN
Signer ID: LUQJMEAH11...
Administrator (or Representative)

8/27/2024
Date

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.

(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 develop and ensure a safe medication system was in place for residents who required assistance and administration with their specific time and/or time-sensitive medication for 4 of 9 residents (Residents 4, 6, 8, and 9). This failed practice placed residents at risk for decline in chronic medical conditions, side effects from unsafe administration times, and/or risk for medication errors.

Findings included...

Review of the facility policy titled, "Medication: Resident-Centered Medication Administration," dated 07/2023, showed that if a resident's physician's order had a specific timeframe or a time-sensitive medication (should be taken at the same time every day to maximize their effectiveness) the ALF would review and schedule appropriately. The policy showed that if the orders indicated only a certain number of times per day to be administered, the ALF needed to evaluate and schedule the medication pass correctly.

Review of the facility's resident agreement, dated 01/2020, showed that resident needs may include medication assistance. The ALF's resident agreement did not include the medication pass timeframes.

In an interview on 08/08/2024 at 1:02 PM, Staff G, Registered Nurse/Campus Director of Nursing, stated that the ALF's medication passes had timeframe windows. Staff G stated that the medication pass windows were:

- AM Pass of 6:00 AM-10:59 AM
- Noon Pass of 11:00 AM-2:59 PM

- PM/Evening Pass of 3:00 PM-7:59 PM
- Bed Time/Hour of Sleep Pass of 8:00 PM-5:59 AM

<Resident 8>

Review of Resident 8's assessment, dated 07/30/2024, showed that they required medication assistance and administration from staff and would be monitored by a licensed nurse. Resident 8's assessment showed that they had a diagnosis of [redacted] and required insulin injections (a medication to regulate blood sugar levels) and fingerstick blood sugar testing by staff.

Review of Resident 8's Negotiated Service Agreement (NSA), dated 07/30/2024, showed that they had diagnoses that included [redacted] and [redacted]. Resident 8's NSA showed that staff were to assist in the assistance and administration of their medication per their physician orders.

Review of Resident 8's physician orders, dated 04/30/2024, showed that they had Novolog insulin injections (rapid-acting insulin) to be administered at 8:00 AM, 12:00 PM, and 5:00 PM.

Review of Resident 8's medication pass report, showed the following incidents when their Novolog insulin was administered outside of the physician's ordered timeframe.

August 2024

- 08/04/2024 the 12:00 PM dose was given at 10:11 AM (one hour and 49 minutes early).
- 08/06/2024 the 12:00 PM dose was given at 10:20 AM (one hour and 40 minutes early).
- 08/07/2024 the 12:00 PM dose was given at 10:14 AM (one hour and 46 minutes early).

July 2024

- 07/03/2024 12:00 PM dose was given at 2:00 PM (two hours late).
- 07/05/2024 12:00 PM dose was given at 1:23 PM (one hour and 23 minutes late).
- 07/14/2024 12:00 PM dose was given at 1:45 PM (one hour and 45 minutes late).
- 07/18/2024 12:00 PM dose was given at 1:32 PM (one hour and 32 minutes late).
- 07/22/2024 8:00 AM dose was given at 10:59 AM and then the noon dose was given at 2:23 PM, which was three hours and 34 minutes from the first dose. The 5:00 PM dose was given at 4:19 PM, which was one hour and 56 minutes from the noon dose.

- 07/29/2024 12:00 PM dose was given at 2:27 PM (two hours and 27 minutes late).

June 2024

- 06/01/2024 8:00 AM dose was given at 9:52 AM (one hour and 52 minutes late).
- 06/01/2024 12:00 PM dose was given at 2:17 PM (two hours and 17 minutes late).
- 06/04/2024 8:00 AM dose was given at 9:33 AM (one hour and 33 minutes late).
- 06/06/2024 8:00 AM dose was given at 9:35 AM and then the 12:00 PM dose was given at 10:49 AM, which was one hour and 14 minutes from the first dose.
- 06/16/2024 8:00 AM dose was given at 10:35 AM and the 12:00 PM dose was given at 12:37 PM, which was two hours and two minutes from the first dose.
- 06/25/2024 12:00 PM dose was given at 1:54 PM (one hour and 54 minutes late).
- 06/27/2024 8:00 AM dose was given at 10:22 AM (two hours and 22 minutes late).
- 06/27/2024 12:00 PM dose was given at 2:06 PM (two hours and six minutes late).
- 06/28/2024 5:00 PM dose was given at 6:35 PM (one hour and 35 minutes late).

May 2024
- 05/04/2024 12:00 PM dose was given at 1:32 PM (one hour and 32 minutes late).
- 05/05/2024 8:00 AM dose was given at 9:52 AM (one hour and 52 minutes late).
- 05/06/2024 8:00 AM dose was given at 10:38 AM (two hours and 38 minutes late).
- 05/13/2024 12:00 PM dose was given at 1:56 PM (one hour and 56 minutes late).
- 05/15/2024 12:00 PM dose was given at 1:43 PM (one hour and 43 minutes late).
- 05/22/2024 12:00 PM dose was given at 1:33 PM (one hour and 33 minutes late).
- 05/23/2024 12:00 PM dose was given at 1:34 PM (one hour and 34 minutes late).
- 05/25/2024 12:00 PM dose was given at 2:13 PM (two hours and 13 minutes late).
- 05/26/2024 12:00 PM dose was given at 2:54 PM (two hours and 54 minutes late).
- 05/28/2024 12:00 PM dose was given at 1:36 PM (one hour and 36 minutes late).

In an interview on 08/12/2024 at 1:26 PM, Collateral Contact 1 (CC1), healthcare professional, stated that they felt that Resident 8's medication was time sensitive and that the ALF's medication pass timeframe was too long and was a safety concern.

In an interview on 08/12/2024 at 2:52 PM, with Collateral Contact 2 (CC2), healthcare professional, stated that Resident 8's insulins are time sensitive medications. CC2 stated that the ALF had notified them twice in July about Resident 8's high blood sugar levels and CC2 felt it was related to the ALFs large medication pass timeframe. In addition, CC2 stated, "You have to give the insulin time to work and the blood sugars too." CC2 stated that with the ALF's large medication pass timeframe, it was not safe for sensitive medications and especially not good for diabetics. Additionally, CC2 stated that they felt that the ALF's large medication timeframe passes were too close together.

<Resident 9>

Review of Resident 9's assessment, dated 07/02/2024, showed that they required medication assistance.

Review of Resident 9's NSA, dated 07/02/2024, showed that they had diagnoses that included [redacted] and [redacted].

Review of Resident 9's physician orders, dated 05/14/2024, showed that they had medications that included levothyroxine and acetaminophen (medication used to treat pain which can cause liver damage if a dose is given prior to four hours from the last dose). Resident 9's levothyroxine was scheduled once daily in the morning and the acetaminophen was scheduled at morning, noon, and evening.

In an interview on 08/13/2024 at 3.07 PM, Collateral Contact 3 (CC3), healthcare professional, stated that Resident 9's levothyroxine and acetaminophen medication were both time sensitive medications. CC3 stated that Resident 9's levothyroxine was supposed to be given 30-60 minutes before breakfast. CC3 stated that if acetaminophen doses were given too close together it could be unsafe. CC3 stated that in general they thought medication passes were to be an hour before or an hour after the scheduled time. CC3 stated that they were not aware of the ALF's large window passes and were concerned. CC3 further stated that the ALF's medication pass timeframe was not acceptable for Resident 8 and not acceptable in general.

Review of Resident 9's medication pass report, showed the following incidents when their medication was administered outside of the physician's ordered timeframe:

August 2024 for acetaminophen

- 08/02/2024, the AM dose was given at 7.34 AM, and the noon dose was given at 11:14 AM, which was three hours and 40 minutes from the first dose. The PM dose was given at 2:22 PM, which was three hours and eight minutes from the noon dose.
- 08/03/2024, the AM dose was given at 8:47 AM and the noon dose was given at 10.48 AM, which was two hours and one minute from the first dose.

July 2024 for acetaminophen

- 07/12/2024, the AM dose was given at 9.10 AM and the noon dose was given at 11:35 AM, which was two hours and 25 minutes from the first dose. The PM dose was given at 2:58 PM, which was three hours and 23 minutes from the noon dose
- 07/15/2024, the PM dose was given at 4.07 PM, which was one hour and two minutes from the noon dose.
- 07/17/2024, the AM dose was given at 9.00 AM and the noon dose was given at 11.39 AM, which was two hours and 39 minutes from the first dose.

June 2024 for acetaminophen

- 06/09/2024, the PM dose was given at 4:20 PM, which was two hours and 15 minutes from the noon dose.
- 06/12/2024, the PM dose was given at 4:26 PM, which was one hour and 38 minutes from the noon dose.
- 06/14/2024, the AM dose was given at 9:05 AM and the noon dose was given at 10:37 AM, which was one hour and 32 minutes from the first dose.
- 06/15/2024, the AM dose was given at 8:15 AM and the noon dose was given at 10:40 AM, which was two hours and 25 minutes from the first dose.

August 2024 for levothyroxine

- 08/04/2024, the AM dose was given at 9:52 AM.

July 2024 for levothyroxine

- 07/12/2024, the AM dose was given at 9:10 AM.

June 2024 for levothyroxine

- 06/09/2024, the AM dose was given at 10:00 AM.
- 06/12/2024, the AM dose was given at 10:19 AM.
- 06/22/2024, the AM dose was given at 9:30 AM.

<Resident 4>

Review of Resident 4's NSA, dated 08/05/2024, showed that they had diagnoses of [redacted] and [redacted]. Resident 4's NSA showed that staff were to administer medications to the resident under the written direction of a physician.

Review of Resident 4's physician orders, dated 04/30/2024, showed that they had a medication order for memantine (used to treat dementia) to be administered in the morning timeframe and in the evening timeframe.

Review of Resident 4's medication pass report showed:

- 05/01/2024-05/31/2024, daily AM and PM medications passes for Resident 4's memantine medication was passed with less than 10 hours between passes for each day in May.
- 06/01/2024-06/30/2024, daily AM and PM medications passes for Resident 4's memantine medication was passed with less than 10 hours between passes for each day in June.
- 07/01/2024-07/31/2024, daily AM and PM medications passes for Resident 4's memantine medication was passed with less than 10 hours between passes for each day in July.
- 08/01/2024-08/07/2024, daily AM and PM medications passes for Resident 4's memantine medication was passed with less than 10 hours between passes for each day in July.

In an interview on 08/14/2024 at 8:56 AM, CC7, healthcare professional, stated that if Resident 4's memantine AM and PM medication passes did not have a 10–12-hour window between passes, it could cause serious effects on the heart and lungs. CC7 stated the ALF's medication pass timeframe could be, "Way too close," if they were within 4 hours of each other and, "Would not be good." CC7 stated that they were not aware of the large medication pass timeframe and that the hour of sleep timeframe was, "Ridiculous." Additionally, CC7 stated that the medication pass timeframes were not safe overall, and there could be, "Many situations that could be dangerous."

<Resident 6>

Review of Resident 6's facility assessment, dated 02/09/2024, showed that the resident had a diagnosis of [redacted] and that they required assistance and administration with their medication which included blood sugar testing and insulin injections.

In an interview on 08/06/2024 at 1:30 PM, Resident 6 stated that their medication was late several times including their insulin.

In an interview on 08/07/2024 at 10:14 AM, Collateral Contact 5 (CC5), Resident 6's representative, stated that one day last week the resident's morning medication, which included insulin, had not been given until 10:30 AM and that the resident had already eaten breakfast.

In an interview on 08/12/2024 at 4:22 PM, Collateral Contact 6 (CC6), a healthcare professional for Resident 6, stated that they felt Resident 6's insulin was a time sensitive medication that must be administered within 1 hour of a meal.

Review of Resident 6's August Medication Administration Record (MAR) showed that on 08/02/2024 the resident's morning insulin, scheduled for 7:30 AM was not administered until 10:57 AM. The MAR did not show the reason the medication was administered late.

Review of Resident 6's July MAR showed that on 07/17/2024 the resident's morning insulin, scheduled for 7:30 AM was not administered until 9:29 AM. The MAR did not show the reason for the late administration time.

In an interview on 08/08/2024 at 8:21 AM, Staff G stated that they were not aware of the late administration of Resident 6's insulin.

In an interview on 08/08/2024 at 11:04 AM CC4, pharmacy professional from the ALF's preferred pharmacy, stated that if the ALF had these large medication timeframe passes it could interfere with time sensitive medications and would be a concern.

In an interview on 08/08/2024 at 1:11 PM, Staff G acknowledged that the resident agreements, new admit paperwork for physician orders, quarterly physician orders, and/or their MAR, did not include the ALF's large medication timeframe passes. Staff G acknowledged that residents, responsible parties, physicians, and/or pharmacist would not have the ability to be aware of the large medication pass timeframe and the opportunity to agree or not agree with it.

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, Ciel Senior Living of the Tri-Cities is or will be in compliance with this law and / or regulation on (Date) 9/27/2024.

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

Ashley Guido, RN
Signer ID: LUQJMEAH11...
Administrator (or Representative)

8/27/2024
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 observation, interview and record review, the Assisted Living Facility (ALF) failed to document and thoroughly investigate, determine the circumstances of the event, and institute preventative measures, when accidents and incidents occurred for

2 of 5 residents (Residents 7 and 8). These failures placed the residents at risk of harm from potential future incidents.

Findings included...

<Resident 7>

Observation on 08/08/2024 at 12:34 PM showed two transfer poles were in Resident 7's one bedroom apartment. Observation showed that there was one transfer pole located next to Resident 7's recliner in their living room and the other next to their bed.

Review of Resident 7's Negotiated Service Agreement (NSA), dated 05/16/2024, showed that the resident was unable to walk, had a transfer pole (a floor to ceiling grab bar to enable a person to sit and stand) required two person assistance to get in and out of bed and their chair, and had a urinary catheter (a tube coming out of the bladder to drain urine from the body into an external collection bag).

Review of a facility incident report, dated 06/06/2024 at 1:31 AM, showed that Resident 7 was found lying on the floor by their bathroom. The report showed that the resident's wheelchair was next to their bed, and their catheter tubing was hooked onto the wheelchair. The report showed the resident stated that they fell while trying to get a glass of water. The incident report did not show that the ALF had determined the circumstances and investigated how Resident 7 had fallen.

Review of an Intermittent Service Plan (ISP), dated 06/06/2024, showed that the staff were to ensure that Resident 7 had on proper footwear and to bring the resident to a common area as tolerated. The ISP did not show preventative measures related to the circumstances that lead to Resident 7 falling during the middle of the night.

Review of a facility incident report, dated 06/29/2024 at 8:31 AM, showed that Resident 7 was found on the floor next to their bed, trapped in between their transfer pole and the bed. The report showed that the resident was wrapped up in their blankets and sheets and they had skin tears on their arms. The incident report did not show an investigation was done to determine the circumstances that lead Resident 7 to fall and become trapped at their bedside.

Review of an ISP, dated 06/29/2024, showed that as a result of Resident 7's fall, the staff were to keep their wheelchair next to their bed with the brakes locked, and to ensure pathways were clear throughout their apartment. The ISP did not show preventative measures related to the circumstances that lead to Resident 7 falling at their bedside.

In an interview on 08/08/2024 at 8:45 AM, Staff G, Registered Nurse/Director of Nursing,

stated that the ALF's investigations were not fully documented for Resident 7.

<Resident 8>

Review of Resident 8's Assessment, dated 07/30/2024, showed that the resident had difficulty with their balance, walking, and had paralysis (loss of the ability to move).

Review of Resident 8's NSA, dated 07/30/2024, showed that they had diagnoses that included [redacted] and [redacted]. Resident B's NSA shewed that staff were to assist with mobility during activities of daily living, extensive assistance with bed mobility, and assistance with transfers.

Review of Resident 8's progress notes, dated 07/11/2024, showed that they had a cut on their tight forearm.

In an interview on 08/12/2024 at 1:26 PM, Resident 8 stated that they had paralysis to their right arm, and that they had a skin tear and bruising to the right forearm that had healed back in July 2024. Resident 6 further stated they had not been assessed by the facility nurse for the injury or asked about the cause of the injury.

In an interview on 08/08/2024 at 2:55 PM, Staff G acknowledged that Resident 8 did not have an investigation fortheir skin tear and bruising.

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, Ciell Senior Living of the Tn-Cities is or will be in compliance with this law and/or regulation on (Date) 9/27/2024 .

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

Ashley Guido, RN
Signer ID: LUQJMEAH11
Administrator (or Representative)

8/27/2024
Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name ofthe new administrator and the effective date ofthe change.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the department within ten calendar days when the ALF had 1 of 1 administrator staff change (Staff A). This failure placed the residents, staff, and the public at risk of not being informed of who directed operations at the facility.

Findings included...

During the entrance conference, on 08/05/2024 at 9:54 AM, Staff I, Campus Assistant Director, stated that Staff A, Campus Executive Director, was the Administrator for the ALF. Staff I further stated that they thought the administrator change form had been completed.

Review of the department's ALF's Secure Tracking and Reporting System (STARS) showed that the administrator on record was not Staff A, and that it was a different individual that was no longer employed with the ALF.

Review of Staff A's personnel file showed that Staff A was hired on 04/07/2020 to be the administrator for the campus.

In an interview on 08/08/2024 at 2:35 PM, Staff H, Regional Operations Manager, stated that their Information Technology (IT) staff were not able to find email communication showing that the change of administrator form had been sent to the department.

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, Ciel Senior Living of the Tri-Cities is or will be in compliance with this law and / or regulation on (Date) 9/27/2024.

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

Ashley Guido, RN — 8/27/2024

Signer ID: LUQJMEAHTT...

Administrator (or Representative) — Date