



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

PSL Associates, LLC
South Hill Village, Assisted Living & Memory Care
611 S Main St Ste 400
Grapevine, TX 76051

RE: South Hill Village, Assisted Living & Memory Care License # 2480

Dear Administrator:

This letter addresses Compliance Determination(s) 31467 (Completion Date 10/24/2023) and 28257 (Completion Date 08/17/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/24/2023 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-2120, WAC 388-78A-2120-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2620-2-a, WAC 388-78A-2489-1, WAC 388-78A-2150-1, WAC 388-78A-2090, WAC 388-78A-2090-1, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-2, WAC 388-78A-2090-2-a, WAC 388-78A-2090-2-b, WAC 388-78A-2090-2-c, WAC 388-78A-2090-3, WAC 388-78A-2090-4, WAC 388-78A-2090-4-a, WAC 388-78A-2090-4-b, WAC 388-78A-2090-5, WAC 388-78A-2090-5-a, WAC 388-78A-2090-5-b, WAC 388-78A-2090-5-c, WAC 388-78A-2090-6, WAC 388-78A-2090-6-a, WAC 388-78A-2090-6-b, WAC 388-78A-2090-6-c, WAC 388-78A-2090-6-d, WAC 388-78A-2090-6-e, WAC 388-78A-2090-7, WAC 388-78A-2090-7-a, WAC 388-78A-2090-7-b, WAC 388-78A-2090-7-c, WAC 388-78A-2090-7-c-i, WAC 388-78A-2090-7-c-ii, WAC 388-78A-2090-7-d, WAC 388-78A-2090-8, WAC 388-78A-2090-8-a, WAC 388-78A-2090-8-b, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-9, WAC 388-78A-2090-10, WAC 388-78A-2090-11, WAC 388-78A-2090-11-a, WAC 388-78A-2090-11-b, WAC 388-78A-2090-11-c, WAC 388-78A-2320-1, WAC 388-78A-2320-1-a, WAC 388-78A-2320-1-b, WAC 388-78A-2320-2-b

The Department staff who did the on-site verification:

Carla Rose, NCI Community Licensor
Mark Sedhom, Assisted Living Facility Licensor

South Hill Village, Assisted Living & Memory Care # 2480

10/24/2023

Page 2 of 2

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

Sincerely,

A handwritten signature in black ink, appearing to read 'S. Jenks'.

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



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License # 2480	Compliance Determination # 28257
Plan of Correction	South Hill Village, Assisted Living & Memory Care	Completion Date
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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 follow-up on 08/16/2023 and 08/17/2023 of:

South Hill Village, Assisted Living & Memory Care
 3117 E Chaser Lane
 Spokane, WA 99223

This document references the following SOD dated: 08/17/2023

The following sample was selected for review during the unannounced on-site visit: 8 of 95 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Antionietta Lettieri-Parkin, Long Term Care Surveyor
 Carla Rose, NCI Community Licensor
 Veronica Jackson, Assisted Living Facility Licensor

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 1, Unit B
 8517 E Trent Ave, Ste 102
 Spokane Valley, WA 99212

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.

S.M.

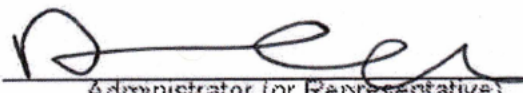
Residential Care Services

08/30/2023

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.

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Administrator (or Representative)

9/5/23
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.
- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify, assess, evaluate, and address the changing needs of 2 of 8 residents (Resident 5 and 6). This failed practice placed Resident 5 at risk of harm due to changes in their condition and Resident 6 at risk of health complications due to high blood pressure and unaddressed chronic back pain.

Findings included...

<Resident 5>

Review of the facility's undated Resident Characteristic Roster showed Resident 5 moved into the facility with their spouse, in a shared living unit, on [REDACTED]/2022.

Review of Resident 5's Functional Needs Assessment, dated 02/10/2023, showed the resident was diagnosed with [REDACTED]

and [REDACTED]
The assessment further showed that Resident 5 used a walker for mobility.

Review of Resident 5's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 09/25/2022, showed Resident 5 had three falls since moving into the facility, hitting their head, and required them to go to the hospital as Resident 5 was prescribed a blood thinner. Documented services in the NSP included "established fall interventions will be followed and adjusted as needed." The NSP further noted "direct interventions are customized to the identified risk factors" but the plan did not identify what those interventions were.

Record review of Resident 5's progress notes showed the following:

-08/01/2023 11:24 AM: Resident remains in community, has not had any adverse effects from a (previous) fall.

-08/09/2023 4:19 AM: Resident 5 had an unwitnessed fall. Reporting associate (staff) stated Resident 5 was on their floor between their bed and closet. Resident 5's spouse reported Resident 5 slipped off the bed. Resident 5 sustained a scratch to their left knee.

-08/09/2023 8:15 AM: Resident had an unwitnessed fall. Reporting associate (staff) stated they found Resident 5 sitting on the floor by their bed. Resident 5 stated they slid out of bed.

In an interview and observation on 08/17/2023 at 10:30 AM, Collateral Contact 1 (CC1) stated they were assisting Resident 5 that day as Resident 5's spouse was in the community. CC1 stated that Resident 5 could not walk much as of late, lost use of their right hand, had trouble letting go of objects from their hands, and had to be fed. CC1 further stated Resident 5 had an increase in drooling. CC1 was asked if Resident 5 had seen a physician in the recent past for these issues. CC1 stated they didn't think Resident 5 had been seen by a physician since their admission to the facility. CC1 stated Resident 5's spouse would need assistance from facility staff to help schedule an appointment for Resident 5 with a physician. Observation of Resident 5 at that time showed their clenched right hand at the side of their body. Resident 5 needed assistance from CC1 to lift their right hand.

In an interview on 08/17/2023 at 11:15 AM, with Staff L, Health and Wellness Specialist and Staff I, Health and Wellness Coordinator, Staff L confirmed the most recent assessment for Resident 5 was the 02/10/2023 assessment. When asked when Resident 5 was last seen by a physician, Staff I stated Resident 5 had not been seen in the recent past. When informed of some of the increased difficulties Resident 5 was having, including losing use of their right hand, Staff L stated that could be a symptom of Resident 5's bursitis worsening, as it would be painful for Resident 5 to use their right hand/arm. Staff L and Staff I confirmed Resident 5 had no recent evaluation or assessment for the changes of condition and a referral for occupational and physical therapy (PT/OT) had been requested but not yet ordered.

Review of Resident 5's file showed no documentation that Resident 5 had a recent evaluation or assessment for their change in condition and increase in falls. Further review showed no documentation regarding follow up for the request for a PT/OT evaluation from Resident 5's physician.

<Resident 6>

Review of Resident 6's NSP, dated 07/24/2023, showed that Resident 6 was diagnosed with [REDACTED] and [REDACTED]. Further review showed the facility was responsible to "report any changes or concerns".

Review of a physician's order, dated 05/17/2023, showed the facility was to check Resident 6's blood pressure twice a day and to contact the cardiologist when the systolic blood pressure (SBP, top number of blood pressure) was greater than 150.

Review of Resident 6's August 2023 medication administration records (MAR), showed an order for the med tech to notify the Health and Wellness Director (HWD) if the SBP was greater than 140 and for the HWD to notify the cardiologist if the SBP was greater than 150. Further review of the MAR for the dates between 08/07/2023 and 08/15/2023 showed the SBP was above 150 on the following dates/times:

08/07/2023 at 8:00 AM SBP 153

08/07/2023 at 8:00 PM SBP 151

08/08/2023 at 8:00 AM SBP 190

08/09/2023 at 8:00 PM SBP 170

08/10/2023 at 8:00 PM SBP 168

08/11/2023 at 8:00 PM SBP 185

08/12/2023 at 8:00 PM SBP 164

08/13/2023 at 8:00 AM SBP 173

08/13/2023 at 8:00 PM SBP 152

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08/14/2023 at 8:00 PM SBP 170

In an interview on 08/17/2023 at 10:45 AM, Staff L and Staff I both confirmed they were not aware that Resident 8's SBP had been above 150. Staff L stated that contacts (faxes) to the cardiologist should have been made and documented in the progress notes. Staff L stated if that contact had been made, a copy of the faxed communications would be kept in the facility's provider binder. Staff L confirmed there were no faxed communications to Resident 8's cardiologist in the binder.

Review of Resident 8's primary care physician letter, dated 04/25/2023, showed that the resident sustained a possible spinal fracture due to a fall.

In an interview on 08/17/2023 at 10:55 AM, Staff I was asked if Resident 8 was assessed for their back injury identified in June 2023 (during the full licensing inspection). Staff I confirmed they had not completed a nursing evaluation of the resident's back pain.

In an interview on 08/17/2023 at 1:25 PM, Resident 8 stated they continued to have back pain from a previous injury in April 2023 and felt they needed to be seen by a doctor. Resident 8 stated that none of the nurses at the facility had assessed their back injury. Resident 8 further stated they previously asked a med aide to speak with a nurse about the injury and they were told to call the nurse's phone. Resident 8 said every time they called the nurse phone, the voicemail was full.

Review of Resident 8's progress notes for the month of August 2023, did not contain any documentation of an evaluation Resident 8's back pain or high SBP.

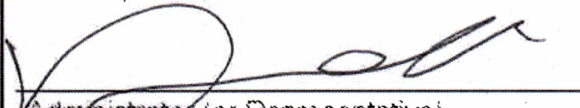
Review of Resident 8's August 2023 medical file showed no contact with the cardiologist.

This is an uncorrected deficiency previously cited on 06/23/2023 and a recurring deficiency previously cited on 03/22/2022 for subsections (2) (a) (3) (a) (b) (4).

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/14/2023 10/1/23

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


Administrator (or Representative)

9/1/23
Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 2 of 2 resident (Residents 1 and 3) pets were current with their immunizations. This failed practice placed Resident 1 and 3 at risk of illness or injury from unvaccinated animals.

Findings included...

Review of the facility's "Resident Pet Policy and Agreement," dated November 2018, showed the facility required licensing and proper vaccination of all pets. The policy further showed proof of license and vaccination must be submitted to the Executive Director prior to move in.

Observation on 08/17/2023 at 10:30 AM, showed Resident 5's had a pet living in their apartment.

Review of the facility's pet records showed no documentation of immunization records for Resident 5's pet.

In an interview on 08/17/2023 at 1:24 PM, Staff A stated that Resident 5's pet veterinarian was contacted that day (after the initiation of the inspection), and the facility was waiting for the veterinarian to fax Resident 5's pet records to the facility.

In another interview on 08/17/2023 at 1:49 PM, with Staff A and Staff K, Staff A stated Resident 1 contacted their veterinarian to have their pet records faxed to the facility. During that interview, Staff K was asked what the process was for obtaining pet records when a resident moved in. Staff K stated Resident 1's pet "just moved in" and the facility "was waiting for the records."

Pet immunization records were not provided to the department at the conclusion of the inspection.

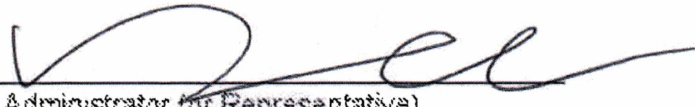
This is an uncorrected deficiency previously cited on 06/23/2023.

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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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/11/2023 10/11/23

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


Administrator (or Representative)

9/1/23
Date

WAC 388-78A-2489 Tuberculosis Test records. The assisted living facility must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the assisted living facility;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain tuberculosis test record results for 2 of 6 staff (Staff D and F). This failure resulted in a lack of medically verifiable documentation of tuberculosis results for Staff D and Staff F and placed residents at risk of exposure to tuberculosis.

Findings included...

Record review on 08/16/2023 at 10:15 AM, of Staff D's, Housekeeper, tuberculosis (TB) skin testing form, showed their second TB skin test was administered on 06/19/2023. There were no results of the second TB test documented on the form.

Record review on 08/16/2023 at 10:17 AM, of Staff F's, Dining Service Partner, TB skin testing form, showed their first TB skin test was administered on 07/27/2023. There were no results of the first TB test documented on the form.

In an interview on 08/16/2023 at 10:19 AM, Staff J, Business Office Manager, was informed that Staff D and Staff F's TB skin testing forms lacked documentation of the TB test results.

In a further interview on 08/16/2023 at 11:24 AM, Staff J provided Staff D and Staff F's TB skin testing documentation again. The skin test documentation that was previously blank was filled in, back dated, and copied. When asked when the documentation was completed, Staff J stated "today" and that Staff I, Health and Wellness Coordinator, "had documentation" to show that Staff D and Staff F's TB skin test results were read on those backdated dates. Staff D's second test result was dated 08/21/2023 as read and Staff F's first test result was dated 07/29/2023 as read.

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In an interview on 08/16/2023 at 11:30 AM, Staff I was asked by the department licensor for the documentation that showed Staff D and Staff F's TB test results were read on the backdated dates. Staff I showed the licensor a cell phone picture and text message dated 07/29/2023, titled Staff F's first name, with a picture of their forearm. After the picture, there was a text that stated, "looks good, thank you." When asked about the original lack of documentation on Staff F's skin testing form, Staff I stated, "it was over a weekend, and I forgot." When asked for Staff D's results, as backdated, and documented on Staff D's form, Staff I showed a text message and picture of a forearm. The message was titled another Staff person's name. When the licensor informed that wasn't the correct staff, Staff I stated, "I gave you the wrong information." Staff I denied having Staff D's second TB test results or seeing Staff F's results in person.

This is an uncorrected deficiency previously cited on 06/23/2023.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/14/2023 10/1/23

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


Administrator (or Representative)

9/1/23
Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the resident or their representative for 5 of 8 residents (Residents 1, 3, 4, 6, and 24). This failed practice placed the residents at risk of unmet care needs related to not signing and acknowledging their own plan of care.

Findings included...

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Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 07/21/2023, showed no signature of the resident or their representative to indicate agreement to the plan.

Review of Resident 3's NSP, dated 07/28/2023, showed no signature of the resident or their representative to indicate agreement to the plan.

Review of Resident 4's NSP, dated 04/28/2023, showed no signature of the resident or their representative to indicate agreement to the plan.

Review of Resident 6's NSP, dated 07/24/2023, showed no signature of the resident or their representative to indicate agreement to the plan.

Review of Resident 24's NSP, dated 05/07/2023, showed no signature of the resident or their representative to indicate agreement to the plan.

In an interview on 08/16/2023 at 1:30 PM, Staff L, Health and Wellness Specialist, stated they did not have a signed NSP for Resident 1 or Resident 6.

In an interview on 08/16/2023 at 1:35 PM, Staff I, Health and Wellness Coordinator, confirmed that Resident 24 did not have a signed NSP.

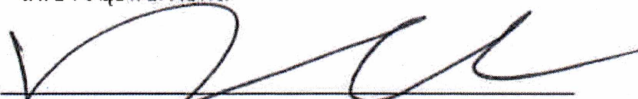
In an interview on 08/16/2023 at 1:55 PM, Staff L stated a signature was not obtained for Resident 3's NSP.

This is an uncorrected deficiency previously cited on 08/23/2023.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/14/23 10/11/23

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


Administrator (or Representative)

9/1/23
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:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(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.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to perform a safety assessment for 1 of 1 resident (Resident 5) with medical devices. This failure placed the

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resident at risk of injury due to having a bed rail on their bed and a transfer assist step stool without a functional assessment to safely use the medical equipment.

Findings included...

Review of Resident 5's Functional Needs Assessment, dated 02/10/2023, showed the resident was diagnosed with [REDACTED]

[REDACTED] and [REDACTED]. Further review of the assessment showed Resident 5 had one assistive device, a walker.

Review of Resident 5's August 2023 progress notes showed Resident 5 had two falls from their bed on 08/09/2023.

In an interview and observation on 08/17/2023 at 10:30 AM, Collateral Contact 1 (CC1) stated they assisted Resident 5 that day as Resident 5's spouse was in the community. CC1 stated that Resident 5 could not walk much as of late, had recently lost use of their right hand, and had trouble letting go of objects from their hands. Observation of Resident 5's bedroom at that time showed a fabric covered bed rail attached to Resident 5's bedside and a step stool with a waist level handle next to the bed. CC1 stated they were unsure if the facility assisted with placement of the medical devices or if a safety assessment had been completed.

In an interview on 08/17/2023 at 11:15 AM, with Staff L, Health and Wellness Specialist and Staff I, Health and Wellness Coordinator, Staff L confirmed the most current assessment for Resident 5 was the 02/10/2023 assessment which did not address the safety and functionality of Resident 5's bed rail or accompanying stool.

This is an uncorrected deficiency cited on 06/23/2023 for subsections (6) (e).

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on

(Date) 10/14/23 10/11/23

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


Administrator (or Representative)

9/1/23
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to obtain a written consent for 1 of 3 residents (Resident 8) sampled for nurse delegation and failed to ensure residents' received insulin administration and blood sugar monitoring by qualified staff (licensed nurse) or through the nurse delegation process for 2 of 2 residents (Residents 8 and 24) who received nurse delegation services. This failure placed the residents at risk of unsafe diabetic care from caregivers who were not trained and supervised through the nurse delegation process.

Findings included....

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator:

- Assesses the ability of the nursing assistant (NA) or home care aid (HCA) to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

- Obtains written consent from the authorized representative for nurse delegation within 30 days.

<Resident 8>

Review of Resident 8's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement), dated 03/22/2023, showed that Resident 8 was diagnosed with [REDACTED] and received delegated nursing services for blood sugar checks and insulin injections (medication administered beneath the skin to lower blood sugar).

Review of Resident 8's Consent for Delegation Process, dated 05/22/2023, showed that a

written consent must be obtained within 30 days of verbal consent. Further review showed that only a verbal consent had been obtained from Resident 8's representative on 05/22/2023.

On 08/16/2023 at 11:45 AM, Staff L, Health and Wellness Specialist, confirmed only a verbal consent for nurse delegation was obtained for Resident 8.

Review of Resident 8's insulin delegation documentation, showed that Staff B, E, G, and H, Med Aides, did not have their competency assessed by the Registered Nurse Delegator (RND) to administer insulin to Resident 8.

Review of Resident 8's August 2023 medication administration record (MAR) showed they had Humalog (fast acting) insulin injections ordered to be administered four times a day and Lantus (long acting) insulin injections to be administered at bedtime.

Review of Resident 8's August 2023 MAR, from 08/07/2023 through 08/16/2023, showed Staff B, E, G, and H, had administered insulin to Resident 8 on the following dates and times:

Humalog insulin:

08/07/2023 4:00 PM and 8:00 PM, Staff E

08/08/2023 8:00 AM Staff G, 4:00 PM and 8:00 PM Staff B

08/09/2023 4:00 PM and 8:00 PM Staff B

08/10/2023 8:00 AM Staff H, 4:00 PM and 8:00 PM Staff E

08/11/2023 8:00 AM Staff H, 4:00 PM and 8:00 PM Staff E

08/12/2023 4:00 PM and 8:00 PM Staff E

08/13/2023 4:00 PM Staff E

08/14/2023 4:00 PM and 8:00 PM Staff E

08/15/2023 8:00 AM Staff G and 8:00 PM Staff B

08/16/2023 8:00 AM Staff G

Lantus insulin:

08/07/2023 Staff E

08/08/2023, Staff B

08/09/2023, Staff B

08/10/2023, Staff E

08/11/2023, Staff E

08/12/2023, Staff E

08/13/2023, Staff E

08/14/2023, Staff E

08/15/2023, Staff B

Resident <24>

Review of Resident 24's NSP, dated 05/07/2023, showed that Resident 24 was diagnosed with [REDACTED] and received delegated nursing services for blood sugar checks and insulin injections.

Review of Resident 24's August 2023 MAR showed they had Humalog insulin injections ordered to be administered three times a day before meals and Lantus insulin to be administered at 8:00 AM daily.

Review of Resident 24's August 2023 MAR's from 08/07/2023 through 08/15/2023, showed Staff B, E, G, and H, had completed blood sugar checks, and administered insulin to Resident 24 for the following administration times:

Lantus every morning at 8:00 AM:

08/08/2023 Staff G

08/09/2023 Staff G

08/10/2023 Staff H

08/11/2023 Staff H

08/15/2023 Staff G

08/16/2023 Staff G

Humalog Insulin:

08/07/2023 4:00 PM Staff E

08/08/2023 8:00 AM and 11:00 AM Staff G

08/08/2023 4:00 PM Staff B

08/09/2023 8:00 AM Staff G

08/09/2023 4:00 PM Staff B

08/10/2023 8:00 AM and 11:00 AM Staff H

08/10/2023 4:00 PM Staff E

08/11/2023 8:00 AM and 11:00 AM Staff H

08/12/2023 4:00 PM Staff E

Statement of Deficiencies	License #: 2480	Compliance Determination # 28257
Plan of Correction	South Hill Village, Assisted Living & Memory Care	Completion Date
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08/13/2023 4:00 PM Staff E

08/14/2023 4:00 PM Staff E

08/15/2023 8:00 AM and 11:00 AM Staff G

Review of Resident 24's insulin delegation documentation showed that Staff B, E, G, and H did not have their competency assessed by the RND to administer insulin and check blood sugars for Resident 24.

In an interview on 08/17/2023 at 10:30 AM Staff H stated they had received no specific training or a competency evaluation by the RND to administer insulin or check blood sugars for any residents. Staff H further stated their training had only been online instruction and neither the RND nor facility nurses had performed a competency evaluation.

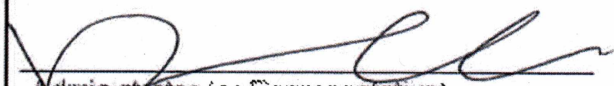
An observation on 08/17/2023 at 11:25 AM showed Staff H checked Resident 24's blood sugar and administered insulin.

This is an uncorrected deficiency previously cited on 06/23/2023 for subsections (1) (a) (b)

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/14/23 10/1/23

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


Administrator (or Representative)

9/1/23
Date



Residential Care Services Investigation Summary Report

Provider/Facility: South Hill Village, Assisted Living & Memory Care
License/Cert.#: 2480
Compliance Determination #: 25338
Investigator: Antonietta Lettieri-Parkin
Investigation Date(s): 06/13/2023 through 06/23/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility
Intake ID: 85987
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):

- 1) A named resident was injured after an accident.
 - 2) A named resident's mental status was not addressed in a timely manner.
-

Investigation Methods:

Sample:	Total residents: 100 Resident sample size: 14 Closed records sample size: 0
Observations:	Named and sampled residents. Facility and adjacent facility environment. Staff interactions with residents. Named resident's medical equipment.
Interviews:	Named and sampled residents. Named resident's representative. Facility staff and management. Other not associated with the facility.
Record Reviews:	Named and sampled resident files. Facility incident reports and investigations.

Investigation Summary:

The named resident had a cognitive impairment and required medical equipment to assist with breathing. 1) the named resident had an incident occur with their medical equipment that caused injuries to their hands. Facility staff assisted the resident after the incident and the resident was medically evaluated. Deficient practice not identified. 2) The same named resident had been experiencing a decline in cognition that was not addressed in their care and services. The resident was placed in a more structured environment after the incident. The facility was cited/deficient practice found under WAC 388-78A-2630 (1) (a), Reporting abuse and neglect as the facility failed to report the allegation immediately.

Conclusion / Action:

☒ 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
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

PSL Associates, LLC
South Hill Village, Assisted Living & Memory Care
611 S Main St Ste 400
Grapevine, TX 76051

RE: South Hill Village, Assisted Living & Memory Care # 2480

Dear Administrator:

This document references the following complaint numbers 84632, 85987, 86341.

The Department completed a full inspection of your Assisted Living Facility on 06/23/2023 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 B

8517 E Trent Ave, Ste 102

Spokane Valley, WA 99212

- 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-3090 Maintenance and housekeeping.

(2) The assisted living facility must provide housekeeping supply room(s):

(c) Equipped with:

(ii) Storage for wet mops;

(iv) Mechanical ventilation to the outside of the assisted living facility.

Wet mop heads were observed in a janitor closet attached to the facility's kitchen. The maintenance director stated that the vent in the room did not operate continuously, but only when the water heater was in use. The area executive director stated that the part to modify the vent had been ordered, and the vent would be repaired.

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

South Hill Village, Assisted Living & Memory Care # 2480

06/23/2023

Page 3 of 3

Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

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

Enclosure



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2480	Compliance Determination # 25338
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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 06/13/2023, 06/14/2023, 06/15/2023, 06/16/2023 and 06/20/2023 of:

South Hill Village, Assisted Living & Memory Care
3117 E Chaser Lane
Spokane, WA 99223

This document references the following complaint numbers: 84632, 85987, 86341.

The following sample was selected for review during the unannounced on-site visit: 14 of 100 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Antonietta Lettieri-Parkin, Long Term Care Surveyor
Janet Quirk, Long Term Care Surveyor
Carla Rose, NCI Community Licensor
Joy Pipgras, LTC Surveyor
Veronica Jackson, Assisted Living Facility Licensor
Raul Gatchalian, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1, Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

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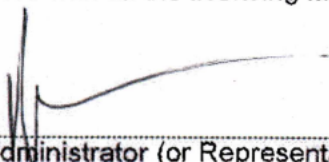


Residential Care Services

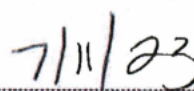
07/05/2023

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-2120 Monitoring residents' well-being. The assisted living facility must:

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:
 - (a) Departure from the resident's customary range of functioning; or
 - (b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.
- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to evaluate and monitor a resident after an incident occurred resulting in an exacerbation (an increase in severity) of a back injury for 1 of 14 residents (Resident 6). The lack of evaluation and monitoring placed the resident at risk of not receiving proper care and services.

Findings included...

Review of Resident 6's Negotiated Service Plan (NSP, the facility's titled negotiated service agreement, dated 01/31/2023, showed the resident was diagnosed with [REDACTED] and [REDACTED]. The NSP did not include any interventions for staff to assess,

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evaluate, or monitor the resident's chronic condition.

Record review of an After Visit Summary from a local emergency department (ED), dated 04/19/2023, showed Resident 6 was diagnosed with [REDACTED] and [REDACTED].

Review of Resident 6's primary care physician note, dated 04/25/2023, showed an evaluation of diagnostic tests that had been completed at the local ED. The letter stated that Resident 6 had "sacral (tailbone) pain after fall five days ago" with "possible fracture at S3-4 (tailbone)."

In an interview on 06/15/2023 at 1:50 PM, and a second interview on 06/16/2023 at 9:50 AM, Resident 6 confirmed they had an incident in their room "a couple months ago." Resident 6 described how they grabbed their four wheeled walker and slipped when attempting to grab their four wheeled walker, severely twisting their back. The next day, Resident 6 called their doctor and had an urgent care provider come to the facility to assess them. Later that week, Resident 6 continued to have significant back pain. The facility transported Resident 6 to the hospital. Resident 6 stated they were given a prescription for hydrocodone (a narcotic pain reliever) for their back pain. Resident 6 stated no one from the facility ever evaluated them or did any follow up assessments.

In an interview on 06/15/2023 at 11:35 AM, Staff D, Health and Wellness Director, stated that if a resident had an incident, a Temporary Service Plan (TSP, a plan to evaluate and monitor after a change in condition) would be filled out to notify care staff of residents that needed to be monitored.

In an interview on 06/16/2023 at 11:51 AM, Staff I, Health and Wellness Coordinator, stated that if a resident sustained an injury, a TSP would be initiated for staff to evaluate and monitor the resident. When asked specifically about Resident 6, Staff I stated they knew about an incident (back injury) in April but did not write a TSP and did not document anything in their chart. Staff I then stated they were not aware that Resident 6 had a possible fracture of the S3-4.

Review of Resident 6's undated medical record showed no documentation of the resident's back injury that occurred in April 2023 or any interventions to address the resident's pain.

This is a recurring deficiency previously cited on and 03/22/2022 for subsections (2)(a)(3)(a)(b)(4).

Plan/Attestation Statement

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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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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

Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure 3 of 3 resident (Residents 5, 13 and 14) pets were current with their vaccinations. This deficient practice placed residents at risk of illness or injury from unvaccinated animals.

Findings included...

Review of the facility's "Resident Pet Policy and Agreement," dated November 2018, showed the facility required licensing and proper vaccination of all pets. The policy further showed proof of license and vaccination must be submitted to the Executive Director prior to move in. There was no statement or directive in the policy on maintaining resident pet vaccinations.

Review of the facility's pet records for Resident 5 and Resident 14's pets showed no examination or immunization records.

Review of Resident 13's pet records showed Resident 13's pet was due for a rabies (a contagious viral disease) vaccine and examination on 01/03/2023. Further review of Resident 13's pet records showed no current vaccines and examinations.

In an interview on 06/13/2023 at 12:17 PM, Staff K, Life Enrichment Director, stated the facility ensured resident pets had their vaccinations in the past. Staff K further stated residents and families forget to provide copies of pet vaccinations, but they were usually provided when residents were admitted to the facility.

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In an interview on 06/13/2023 at 4:11 PM, Staff A, Area Executive Director, stated that they were aware that the facility's resident pet immunization records were not up to date.

Observation on 06/15/2023 at 03:00 PM, showed Resident 5 had a cat in their apartment.

In an interview on 06/15/2023 at 4:15 PM, Staff A stated they do not have any records on Resident 5's cat.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/07/23</u>.	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
_____ Administrator (or Representative)	<u>7/11/23</u> Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

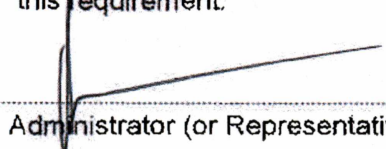
Based on interview and record review, the facility failed to ensure that 1 of 6 staff (Staff E) had a Washington state name and date of birth background check submitted to the department's background check central unit prior to its expiration. This deficient practice placed residents at risk of receiving care and services by potentially disqualified staff.

Findings included ...

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Review of Staff E's, Medication Aide, personnel file on 06/14/2023 showed a hire date of 05/05/2015. Review of Staff E's last two Washington state name and date of birth background checks showed dates of 12/31/2020 and 06/14/2023, the date Staff E's file was reviewed for the inspection.

When interviewed on 06/14/2023 at 3:05 PM, Staff J, Business Office Manager stated "I knew it [Staff E's background check] was over two years old. We ran it today."

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/07/23</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>7/11/23</u> Date

WAC 388-78A-2480 Tuberculosis Testing Required.

- (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.
- (2) For purposes of WAC 388-78A-2481 through 388-78A-2489, "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that tuberculosis screening was completed within three days of hire for 1 of 6 staff (Staff D). This failure placed residents at risk for exposure to tuberculosis infection.

Findings included...

Review of the undated personnel records for Staff D, Health and Wellness Director, showed no documentation that a tuberculosis (TB, a communicable respiratory disease) screening had been completed.

In an interview on 06/14/2023 at 3:05 PM, Staff J, Business Office Manager, stated they were unable to locate documentation for TB screening for Staff D.

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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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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

Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a second tuberculosis test was completed for 1 of 6 staff (Staff A). This failure placed residents at risk for exposure to tuberculosis infection.

Findings included...

Review of Staff A's personnel file showed they were the Area Executive Director and had a hire date of 07/12/2021. Review of Staff A's personnel file showed they completed their step one tuberculosis (TB) skin test on 04/18/2022, and the step two section of the form was left blank. Staff A's personnel file did not contain a completed second TB test.

In an interview on 06/14/2023 at 3:05 PM, Staff J, Business Office Manager, stated they were aware there was no second step TB testing completed for Staff A.

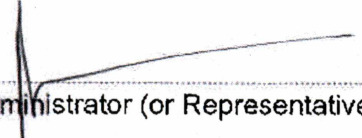
In an interview on 06/14/2023 at 3:51 PM, Staff A confirmed they had not had a second TB test.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2480	Compliance Determination # 25338
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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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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


Administrator (or Representative)

7/21/23
Date

WAC 388-78A-2489 Tuberculosis Test records. The assisted living facility must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the assisted living facility;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain tuberculosis test record results for 2 of 6 staff (Staff B and C). This failure resulted in no documented second step results for Staff B and C and placed residents at risk of exposure to tuberculosis.

Findings included...

Review of Staff B's personnel file showed they were hired on 02/16/2023 as a dining services partner. Review of Staff B's tuberculosis (TB, a communicable respiratory disease) skin testing form dated 03/03/2023, showed they received their second step TB skin test on that date. There was no documentation on the form to show when the test was read or what the results were.

Review of Staff C's personnel file showed they were hired on 02/23/2023 as a dining services partner. Review of Staff C's TB skin testing form dated 03/03/2023, showed their TB skin test was completed on that date. There was no documentation on the form to show when the test was read or what the results were.

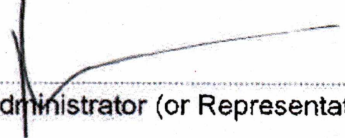
In an interview on 06/14/2023 at 3:05 PM, Staff J, Business Office Manager, acknowledged they did not have TB testing results documentation for Staff B and C.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2480	Compliance Determination # 25338
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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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23

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


Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that negotiated service agreements were signed by the resident or representative for 6 of 14 residents (Residents 2, 4, 6, 10, 11, and 12). This failed practice placed the residents at risk of unmet care needs related to not signing and acknowledging their own plan of care.

Findings included...

In an interview on 06/14/2023 at 09:45 AM, Staff D, Health and Wellness Director, stated that the signed plans should be located in the Negotiated Service Plan (NSP, the facility's titled Negotiated Service Agreement) binder and/or resident charts.

<Resident 2>

Review of Resident 2's NSP, dated 06/04/2023, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

In an interview on 06/15/2023 at 9:45 AM, Staff D stated that Resident 2's representative was supposed to come to the facility to sign the current NSP.

Review of Resident 2's undated medical record showed the previous year's NSP was also not signed by the resident or their representative.

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<Resident 4>

Review of Resident 4's NSP dated 04/28/2023, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

In an interview on 06/15/2023 at 10:55 AM, Staff D acknowledged Resident 4's NSP was not signed.

<Resident 6>

Review of Resident 6's NSP, dated 01/31/2023, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

In an interview on 06/15/2023 at 1:50 PM, Resident 6 confirmed that staff did not review the NSP with them. Resident 6 stated they had requested twice, to have the NSP sent to their email for review, but they have not received a copy yet.

In an interview on 06/15/2023 at 3:05 PM, Staff D stated they were unable to find a signed NSP for Resident 6.

<Resident 10>

Review of Resident 10's NSP, dated 12/17/2022, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

<Resident 11>

Review of Resident 11's NSP, dated 01/31/2023, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

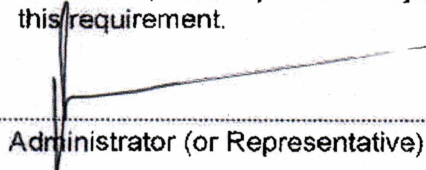
In an interview on 06/20/2023 at 11:50 AM, Staff D stated they were unable to locate a signed NSP for Resident 11.

<Resident 12>

Review of Resident 12's NSP, dated 02/08/2023, showed the plan did not contain signature(s) by the resident or their representative to indicate agreement to the plan.

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In an interview on 06/20/2023 at 10:00 AM, Staff I, Health and Wellness Coordinator, stated they were unable to locate a signed NSP for Resident 12.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/07/23</u>. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>7/11/23</u> 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:

- (1) Individual's recent medical history, including, but not limited to:
 - (a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;
 - (b) Chronic, current, and potential skin conditions; or
 - (c) Known allergies to foods or medications, or other considerations for providing care or services.
- (2) Currently necessary and contraindicated medications and treatments for the individual, including:
 - (a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;
 - (b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and
 - (c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.
- (3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

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(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(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.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

(8) Individual's level of personal care needs, including:

(a) Ability to perform activities of daily living;

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living

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facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete a full assessment within 14 days for 2 of 2 residents (Residents 7 and 10) and complete a safe smoking assessment for 1 resident (Resident 7). This failure placed the residents at risk of injury and unmet care needs.

Findings included...

<Resident 7>

Review of Resident 7's progress notes showed the resident moved into the facility on [REDACTED]/2023.

Review of Resident 7's Functional Evaluation (the facility's titled assessment) completed on 05/19/2023 by Staff D, Health and Wellness Director, showed the resident was a smoker.

Review of Resident 7's undated medical record and the facility's Negotiated Service Plan binder showed no 14-day assessment. There was no documentation of an assessment to determine if Resident 7 was safe to smoke unsupervised.

In an interview on 06/15/2023 at 9:00 AM, Staff D stated they were aware Resident 7's 14-day assessment was not completed. Staff D further stated they had not completed a smoking safety assessment for the resident.

Observation on 06/15/2023 at 11:14 AM, showed Resident 7's room smelled of cigarette smoke and a no smoking sign was posted on the exterior deck railing.

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In an interview on 06/15/2023 at 11:18 AM, Resident 7 stated they usually smoked on the balcony adjacent to their room.

In an interview on 6/20/2023 at 9:30 AM, Staff H, Maintenance Director, stated they had witnessed Resident 7 smoking on their balcony.

<Resident 10>

Review of Resident 10's undated preadmission assessment showed the resident moved into the facility on [REDACTED]/2023.

Review of Resident 10's Functional Needs Assessment, dated [REDACTED]/2023, showed the resident's assessment was completed 45 days after Resident 10's admission and not within 14 days as required.

In an interview on 06/15/2023 at 3:54 PM, Staff L, Regional Nurse, stated they were unaware as to why Resident 10's assessment was not completed within 14 days.

Plan/Attestation Statement

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

Administrator (or Representative)

7/11/23
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

(2) The assisted living facility must prominently post so it is readily visible to staff,

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residents and visitors, the department's toll-free telephone number for reporting resident abuse and neglect.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to report an allegation of neglect immediately to the Complaint Resolution Unit as required for 1 of 14 residents (Resident 10) and failed to post the department's Aging and Disability Services Administration Complaint Resolution Unit hotline number where it was readily visible. This failure precluded the department from having immediate knowledge to conduct an investigation of the allegation, precluded residents and visitors from having access to reporting information, and placed residents at risk of harm.

Findings included...

Per RCW 74.34.020 (15) "Neglect" means (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

Per RCW 74.34.035 (1) When there is reasonable cause to believe that abuse or neglect of a vulnerable adult has occurred, mandated reporter shall immediately report to the department.

<Reporting>

Review of Resident 10's incident report (IR), dated 06/05/2023, showed at 6:30 AM, the resident's smoke alarm was activated. Resident 10 reported to staff they tried to melt their oxygen cords together over their toaster and there was a "boom." The oxygen cord melted off at their chin and the remainder of the cord connected to the oxygen concentrator was "black and melted." The IR further stated Resident 10's kitchen floor was black with melted plastic, tubing in the kitchen sink was black, both of the resident's hands and fingers were black and burnt, and their upper right arm was burnt. Resident 10 was sent to a local emergency department (ED) for a medical evaluation.

Review of a letter, dated 06/05/2023, signed by Resident 10's primary care provider, showed Resident 10 was appropriate for memory care (placement) due to advanced Alzheimer's disease (a progressive disease that destroys memory and mental functioning) and significant safety concerns. The letter further stated Resident 10 was in immediate need of memory care placement for their safety.

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Review of the facility's online report to the department, dated 06/14/2023, showed the allegation of neglect was reported nine days after the incident and after the initiation of the full licensing inspection.

Observation and interview on 06/15/2023 at 9:54 AM, showed Resident 10 had visible peeling skin on their fingertips. When asked how their fingers were burned, Resident 10 stated they got "too close to a toaster." Resident 10 demonstrated and verbalized confusion, including stating they lived with their eight grandchildren.

In an interview on 06/15/2023 at 10:17 AM, Staff D, Health and Wellness Director, stated Resident 10 was confused and declining. Staff D further stated Resident 10 needed a change in condition assessment at the time of the incident.

<CRU reporting information and posting>

During the environmental tour on 06/13/2023 at 11:19 AM, postings of the department's Aging and Disability Services Administration Complaint Resolution Unit (CRU) hotline were not observed to be visible to residents or visitors.

Observation on 06/14/2023 at 2:58 PM, showed no postings of the department's Aging and Disability Services Administration CRU hotline visible to residents or visitors throughout the facility.

In an interview on 06/15/2023 at 3:09 PM, Staff A, Area Executive Director, stated they believed the signs were posted "all over" the facility. At that same time, Staff J, Business Office Manager, stated it was posted on the activity board.

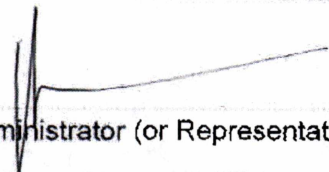
Observation on 06/15/2023 at 3:10 PM, showed no postings of the department's CRU hotline number to be present on the activity board.

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WAC 388-78A-2210 Medication services.

- (1) An assisted living facility providing medication service, either directly or indirectly, must:
- (a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and
 - (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 observation, interview, and record review, the facility failed to ensure medications were administered as ordered and as documented in their negotiated service agreement for 3 of 14 residents (Resident 1, 6, and 8). This failure resulted in uncontrolled pain for Resident 6, placed Resident 8 at risk of health complications, and placed Resident 1 at risk of not receiving their medications as prescribed.

<Resident 1>

Review of Resident 1's Negotiated Service Plan (NSP, the facility's titled Negotiated Service Agreement), dated 02/13/2023, showed Resident 1 required medication assistance.

Observation on 06/15/2023 at 2:15 PM showed Staff F, Medication Aide, came into Resident 1's apartment while being interviewed by department licensors. Staff F stated to Resident 1 they had the resident's medication and that they would leave it on the resident's counter. Staff F left a medication cup on Resident 1's counter and left the apartment. Resident 1 was not observed to take the medications.

<Resident 6>

Review of Resident 6's NSP, dated 01/31/2023, showed the resident required medication

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assistance.

Review of records from Resident 6's primary care physician, dated 04/25/2023, showed a history of a compression fracture in the lumbar spine (lower back) and a "possible fracture at S3-4" (tailbone).

In an interview on 06/15/2023 at 1:50 PM, Resident 6 stated that medication aides left their medications on the table without observing to ensure the medications were taken. Resident 6 then stated they had narcotic pain medications for their chronic back pain scheduled to be administered with their 8:00 AM and 2:00 PM medications. The resident further stated they did not get their scheduled 8:00 AM medications on 06/04/2023. Resident 6 stated they pressed their call pendant twice on 06/04/2023, asking for their medications because their back pain had become severe. When staff arrived, they told Resident 6 it was too late to give the 8:00 AM medications and they would need to wait until the next scheduled dose at 2:00 PM.

Review of the call pendant history report, dated 06/04/2023, showed that Resident 6 had pressed their call pendant twice on 06/04/2023, at 10:13 AM, and again at 10:49 AM.

Review of Resident 6's June 2023 medication administration record (MAR) showed documentation that the resident did not receive their 8:00 AM medications on 06/04/2023 which included hydrocodone (a narcotic pain medication). Further review of the MAR showed the documented reason medications were not administered on 06/04/2023 was "outside the designated time parameter."

In an interview on 6/16/2023 at 8:50 AM, Staff D, Health and Wellness Director, stated the medication aide that was assigned to administer medications to Resident 6 on 06/04/2023 was from another facility and was unfamiliar with the residents. Staff D confirmed the medication aide was late administering medications. When the medication aide got to Resident 6, the time was too close to the next scheduled dose. When asked if another qualified staff could have assisted with the medication pass, Staff D stated they were not aware there was an issue until it was too late.

<Resident 8>

Review of Resident 8's NSP, dated 03/22/2023, showed the resident was diagnosed with [REDACTED] and [REDACTED]

The NSP further showed the resident required medication assistance.

Review of Resident 8's physician orders, dated 02/24/2023, showed metoprolol 25milligrams (mg) (a medication used to treat high blood pressure) was ordered one tablet by mouth two times daily and to hold the medication if Resident 8's heart rate (HR) was less than 60 or their systolic blood pressure (SBP, top number in a blood pressure) was less than 110, based on vital signs (HR and SBP) measured at the time of administration.

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Review of Resident 8's April 2023, May 2023, and June 2023 MARs showed no documentation that Resident 8's blood pressure (BP) or HR was checked with the administration of the metoprolol.

Review of Resident 8's Vitals Report, from 04/16/2023 through 06/16/2023, showed the residents BP was checked once a week.

Review of Resident 8's June 2023 treatment administration report (TAR) showed the residents BP was checked on Sundays.

In an interview on 06/16/2023 at 2:56 PM, Staff E, Medication Aide, stated they checked Resident 8's BP and HR once a week on Sundays.

In an interview on 06/16/2023 at 3:14 PM, Staff I, Health and Wellness Coordinator, reviewed the MAR and TAR for Resident 8 with the department licensor. Staff I confirmed that the MAR did not show an order (instructions) to check the BP or HR twice a day with the medication administration. Staff I stated they would get the order corrected on the MAR to ensure BP and HR checks were done with the metoprolol administration.

Review of Resident 8's April 2023, May 2023, and June 2023 MARs, showed the resident was prescribed Humalog insulin (injectable medication used to lower blood sugar, BS) as follows:

Inject 4 units subcutaneously (under the skin) 2 times daily (breakfast and lunch) plus sliding scale (insulin dose based on the amount of sugar in the blood). The sliding scale order was written as follows:

Inject subcutaneously 4 times daily with meals and bedtime.

If blood sugar less than 150 = 0 units

If blood sugar 151-200 = 1 unit

If blood sugar 201-250 = 2 units

If blood sugar 251-300 = 3 units

If blood sugar 301-350 = 4 units

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If blood sugar 351-400 = 5 units

If blood sugar 400 or greater = 6 units and call the doctor.

In an interview on 6/16/2023 at 11:51 AM, Staff I confirmed the correct way to document insulin administration in Resident 8's MAR, would show a total number that included the 4 units and the additional units added for the sliding scale.

Review of Resident 8's May 2023 and June 2023 MARs showed Staff G, Medication Aide, had administered an incorrect number of units of insulin on the following dates:

05/02/2023 at 8:00 AM, blood sugar 272, documented dose 6 units, should have been 7 units.

05/03/2023 at 8:00 AM, blood sugar 301, documented dose 6 units, should have been 8 units.

05/03/2023 at 12:00 PM, blood sugar 109, documented dose 5 units, should have been 4 units.

05/05/2023 at 8:00 AM, blood sugar 209, documented dose 4 units, should have been 6 units.

05/09/2023 at 8:00 AM, blood sugar 208, documented dose 5 units, should have been 6 units.

05/09/2023 at 12:00 PM, blood sugar 208, documented dose 5 units, should have been 6 units.

05/10/2023 at 8:00 AM, blood sugar 208, documented dose 5 units, should have been 6 units.

05/10/2023 at 12:00 PM, blood sugar 298, documented dose 5 units, should have been 7 units.

05/14/2023 at 8:00 AM, blood sugar 280, documented dose 4 units, should have been 7 units.

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05/14/2023 at 12:00 PM, blood sugar 238, documented dose 4 units, should have been 6 units.

05/15/2023 at 8:00 AM, blood sugar 258, documented dose 4 units, should have been 7 units.

05/15/2023 at 12:00 PM, blood sugar 307, documented dose 5 units, should have been 8 units.

05/16/2023 at 8:00 AM, blood sugar 204, documented dose 4 units, should have been 6 units.

05/16/2023 at 12:00 PM, blood sugar 245, documented dose 4 units, should have been 8 units.

05/17/2023 at 8:00 AM, blood sugar 195, documented dose 3 units, should have been 5 units.

05/17/2023 at 12:00 PM, blood sugar 221, documented dose 5 units, should have been 6 units.

05/19/2023 at 8:00 AM, blood sugar 200, documented dose 4 units, should have been 5 units.

05/19/2023 at 12:00 PM, blood sugar 200, documented dose 4 units, should have been 5 units.

05/20/2023 at 8:00 AM, blood sugar 278, documented dose 4 units, should have been 7 units.

05/20/2023 at 12:00 PM, blood sugar 275, documented dose 4 units, should have been 7 units.

05/23/2023 at 12:00 PM, blood sugar 235, documented dose 8 units, should have been 6 units.

05/24/2023 at 8:00 AM, blood sugar 176, documented dose 4 units, should have been 5 units.

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05/24/2023 at 12:00 PM, blood sugar 172, documented dose 8 units, should have been 5 units.

05/25/2023 at 8:00 AM, blood sugar 275, documented dose 6 units, should have been 7 units.

05/25/2023 at 12:00 PM, blood sugar 298, documented dose 6 units, should have been 7 units.

05/26/2023 at 8:00 AM, blood sugar 278, documented dose 6 units, should have been 7 units.

05/26/2023 at 12:00 PM, blood sugar 277, documented dose 6 units, should have been 7 units.

05/27/2023 at 8:00 AM, blood sugar 400, documented dose 8 units, should have been 10 units.

05/27/2023 at 12:00 PM, blood sugar 245, documented dose 7 units, should have been 6 units.

05/30/2023 at 8:00 AM, blood sugar 218, documented dose 5 units, should have been 6 units.

05/30/2023 at 12:00 PM, blood sugar 255, documented dose 5 units, should have been 7 units.

05/31/2023 at 12:00 PM, blood sugar 287, documented dose 5 units, should have been 7 units.

06/01/2023 at 12:00 PM, blood sugar 256, documented dose 5 units, should have been 7 units.

06/01/2023 at 8:00 AM, blood sugar 278, documented dose 5 units, should have been 7 units.

06/02/2023 at 12:00 PM, blood sugar 387, documented dose 8 units, should have been 9 units.

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06/03/2023 at 8:00 AM, blood sugar 270, documented dose 6 units, should have been 7 units.

06/03/2023 at 12:00 PM, blood sugar 245, documented dose 5 units, should have been 6 units.

06/09/2023 at 8:00 AM, blood sugar 287, documented dose 6 units, should have been 7 units.

06/10/2023 at 8:00 AM, blood sugar 280, documented dose 6 units, should have been 7 units.

06/10/2023 at 12:00 PM, blood sugar 160, documented dose 6 units, should have been 4 units.

06/13/2023 at 8:00 AM, blood sugar 210, documented dose 4 units, should have been 6 units.

06/16/2023 at 8:00 AM, blood sugar 205, documented dose 5 units, should have been 6 units.

Review of Resident 8's April 2023, May 2023, and June 2023 MARs showed an order for Humalog insulin to be administered per the sliding scale at dinner and bedtime. Further review of the MARs showed no documentation of the blood sugar or how many units of Humalog insulin were administered per the sliding scale.

Review of Resident 8's April 2023, May 2023, and June 2023 MARs showed an order for Lantus (long-acting insulin) to be administered as follows: 20 units subcutaneously at bedtime and to decrease dose by 2 units if having any blood sugars below 80. Further review of the MAR's showed no documentation of the blood sugar or if the units of Lantus insulin had to be reduced based on the blood sugar.

Plan/Attestation Statement

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Administrator (or Representative)

7/11/23
Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

- (1) The residents' characteristics and needs;
- (2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to secure potentially hazardous supplies. This failed practice placed 23 residents with cognitive impairment at risk of harm.

Findings included...

During the environmental tour of the facility on 06/13/2023 at 11:19 AM, with Staff H, Maintenance Director, the following was observed to be accessible to residents:

-A gasoline container, with a gasoline label, contained an unknown substance on the back sidewalk.

-A container of Ecolab 66 Heavy Duty Alkaline Bathroom Cleaner and Disinfectant on the back sidewalk.

-Unsecured bleach and Raid Bug Spray/insecticide in the 2nd floor resident laundry room.

-Unsecured bleach in the 3rd floor resident laundry room.

In an interview with Staff H, during the environmental rounds, they stated the gasoline container was filled with sanitizer and that it was there before they started working at the facility the year prior. Staff H further stated that the bleach and insecticide in the resident laundry rooms did not belong there.

In an interview on 06/13/2023 at 4:23 PM, Staff A, Area Executive Director, stated the gasoline container was used to hold spray disinfectant during the COVID-19 epidemic and it should not have been outside accessible to residents.

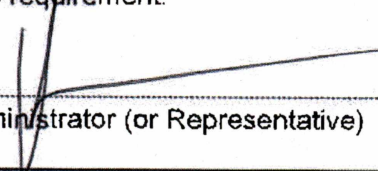
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(Date) 8/07/23

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


Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation to show the required nurse delegation criteria was followed for 14 of 100 residents (Residents 8, 9, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26) sampled for nurse delegation and failed to ensure one staff (Staff G) was credentialed and qualified to provide insulin injections for 1 of 1 resident (Resident 8). This failure placed 14 nurse delegated residents at risk of unsafe medication administration from caregivers who were not trained and supervised through the nurse delegation process and placed Resident 8 at risk of harm.

Findings included...

Per WAC 246-840-930, Criteria for nurse delegation, before delegating a nursing task, the registered nurse delegator:

-Verifies the nursing assistant (NA) or home care aid (HCA) is currently registered or certified in Washington state without restriction.

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-Assesses the ability of the NA or HCA to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

-Obtains written consent from the authorized representative for nurse delegation within 30 days.

-Provide specific, written delegation instructions for each task to the NA or HCA with a copy maintained in the resident's file.

-Document teaching done and a return demonstration, or other method for verification of competency.

In an interview on 06/16/2023 at 8:44 AM, Staff I, Health and Wellness Coordinator, stated they had "some" nurse delegation (ND) records. Staff I was asked for resident consents, resident delegated task instructions, and 90-day reviews. Staff I stated they would see what ND documentation the facility had.

In an interview on 06/16/2023 at 1:48 PM, Staff A, Area Executive Director, stated the facility had a new contracted nurse delegation agency providing nurse delegation services to the facility. Staff A further stated the new agency started approximately one month prior to the initiation of the licensing inspection and prior to that, Staff I did the nurse delegation services for the facility.

In an interview on 06/16/2023 at 2:00 PM, Staff D, Health and Wellness Director and Staff I confirmed 14 residents in the facility were delegated for various medication and treatments including topical medications, insulin administration, blood sugar checks, eyedrops, and nasal sprays.

In an interview on 06/16/2023 at 3:04 PM, Staff A stated Staff I had been looking for the nurse delegation paperwork, stating they "had it in a binder, but now it's not there", confirming they could not locate their nurse delegation paperwork binder.

Review of Resident 8's ND documentation showed the consent, ND task instructions, and visit notes/ND staff competency checks were initiated and signed on 05/22/2023, by the assuming ND agency. Further review of Resident 8's ND paperwork did not show that Staff E, Medication Aide, Staff M, Medication Aide, and Staff N, Medication Aide, were delegated to perform ND tasks for Resident 8. Staff O, Medication Aide was delegated on 06/12/2023.

Review of Staff G's, Medication Aide, ND paperwork showed they did not have an active Department of Health (DOH) credential required to perform nurse delegated tasks.

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In an interview on 06/16/2023 at 11:51 AM, Staff I confirmed Staff G was not delegated and Staff G had administered insulin unsupervised.

Review of Resident 8's April 2023, May 2023, and June 2023 medication administration records (MARs), showed Staff E, Staff G, Staff M, Staff N, and Staff O, had administered insulin to Resident 8.

Review of Resident 8's May 2023 and June 2023 MARs showed Staff G administered the incorrect number of units of insulin to Resident 8 on the following dates:

05/02/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

05/03/2023 at 8:00 AM, documented dose 6 units, should have been 8 units.

05/03/2023 at 12:00 PM, documented dose 5 units, should have been 4 units.

05/05/2023 at 8:00 AM, documented dose 4 units, should have been 6 units.

05/09/2023 at 8:00 AM, documented dose 5 units, should have been 6 units.

05/09/2023 at 12:00 PM, documented dose 5 units, should have been 6 units.

05/10/2023 at 8:00 AM, documented dose 5 units, should have been 6 units.

05/10/2023 at 12:00 PM, documented dose 5 units, should have been 7 units.

05/14/2023 at 8:00 AM, documented dose 4 units, should have been 7 units.

05/14/2023 at 12:00 PM, documented dose 4 units, should have been 6 units.

05/15/2023 at 8:00 AM, documented dose 4 units, should have been 7 units.

05/15/2023 at 12:00 PM, documented dose 5 units, should have been 8 units.

05/16/2023 at 8:00 AM, documented dose 4 units, should have been 6 units.

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05/16/2023 at 12:00 PM, documented dose 4 units, should have been 8 units.

05/17/2023 at 8:00 AM, documented dose 3 units, should have been 5 units.

05/17/2023 at 12:00 PM, documented dose 5 units, should have been 6 units.

05/19/2023 at 8:00 AM, documented dose 4 units, should have been 5 units.

05/19/2023 at 12:00 PM, documented dose 4 units, should have been 5 units.

05/20/2023 at 8:00 AM, documented dose 4 units, should have been 7 units.

05/20/2023 at 12:00 PM, documented dose 4 units, should have been 7 units.

05/23/2023 at 12:00 PM, documented dose 8 units, should have been 6 units.

05/24/2023 at 8:00 AM, documented dose 4 units, should have been 5 units.

05/24/2023 at 12:00 PM, documented dose 8 units, should have been 5 units.

05/25/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

05/25/2023 at 12:00 PM, documented dose 6 units, should have been 7 units.

05/26/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

05/26/2023 at 12:00 PM, documented dose 6 units, should have been 7 units.

05/27/2023 at 8:00 AM, documented dose 8 units, should have been 10 units.

05/27/2023 at 12:00 PM, documented dose 7 units, should have been 6 units.

05/30/2023 at 8:00 AM, documented dose 5 units, should have been 6 units.

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05/30/2023 at 12:00 PM, documented dose 5 units, should have been 7 units.

05/31/2023 at 12:00 PM, documented dose 5 units, should have been 7 units.

06/01/2023 at 12:00 PM, documented dose 5 units, should have been 7 units.

06/01/2023 at 8:00 AM, documented dose 5 units, should have been 7 units.

06/02/2023 at 12:00 PM, documented dose 8 units, should have been 9 units.

06/03/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

06/03/2023 at 12:00 PM, documented dose 5 units, should have been 6 units.

06/09/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

06/10/2023 at 8:00 AM, documented dose 6 units, should have been 7 units.

06/10/2023 at 12:00 PM, documented dose 6 units, should have been 4 units.

06/13/2023 at 8:00 AM, documented dose 4 units, should have been 6 units.

06/16/2023 at 8:00 AM, documented dose 5 units, should have been 6 units.

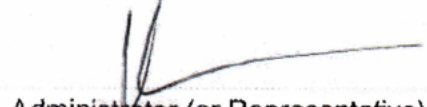
In a further interview with Staff A on 06/21/2023 at 2:40 PM, Staff A stated the facility never found the previous ND paperwork prior to the new ND agency assuming ND services.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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

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Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received the care and services outlined in their negotiated service agreement for 1 of 14 residents (Resident 5). This failure placed the resident at risk for health complications and decreased quality of life due to not receiving the care that was agreed upon in the negotiated service agreement.

Findings included...

Review of Resident 5's Functional Needs Assessment, dated 02/10/2023, showed that Resident 5 was diagnosed with [REDACTED]

and [REDACTED]

Review of the Resident 5's Functional Needs Service Plan (NSP, the facility's titled negotiated service agreement), dated 02/10/2023, showed the resident would receive bathing assistance from the staff three times per week, on Sundays, Wednesdays, and Fridays.

Review of the facility's Shower Schedule showed that Resident 5 was to receive showers between 2pm and 10pm on Sundays, Wednesdays, and Fridays.

Review of Resident 5's shower records, completed by facility staff after providing bathing assistance between 05/10/2023 and 06/16/2023, showed that Resident 5 received shower assistance on the following dates:

- Wednesday, 05/10/2023
- Sunday, 05/14/2023
- Wednesday, 05/17/2023
- Thursday, 05/18/2023

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- Sunday, 05/21/2023
- Friday, 05/26/2023
- Sunday, 05/28/2023
- Friday, 06/02/2023
- Sunday, 06/04/2023
- Thursday, 06/15/2023
- Friday, 06/16/2023

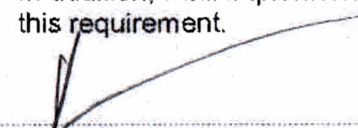
The shower records showed Resident 5 missed two showers the week of 05/07/2023 through 05/13/2023, one shower the week of 05/21/2023 through 05/27/2023, one shower the week of 05/28/2023 through 06/03/2023, two showers the week of 06/04/2023 through 06/10/2023, and one shower the week of 06/11/2023 through 06/17/2023.

In an interview on 06/15/2023 at 3:00 PM, Collateral Contact 1 (CC1) stated they were not satisfied that Resident 5 was not receiving three showers per week, as agreed upon.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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


Administrator (or Representative)

7/11/23
Date

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, and:

- (1) Who has received the diagnosis or treatment within the previous two years; and
- (2) Whose diagnosis was made by, or treatment provided by, one of the following:
 - (a) A licensed physician;
 - (b) A mental health professional;
 - (c) A psychiatric advanced registered nurse practitioner; or

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(d) A licensed psychologist.

This requirement was not met as evidenced by:

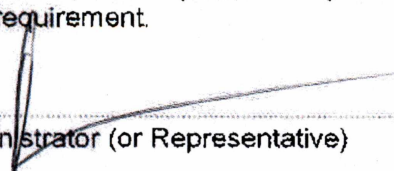
Based on interview and record review, the facility failed to ensure that specialized training for mental illness was completed for 1 of 6 staff (Staff D). This failed practice placed two residents diagnosed with mental illness at risk of improper care by untrained staff.

Findings included...

Review of the undated personnel file for Staff D, Health and Wellness Director, showed no documentation of specialized training for mental illness.

Review of the facility's undated Resident Characteristics Roster showed there were two residents with a mental illness diagnosis.

In an interview on 06/14/2023 at 3:18 PM, Staff A, Area Executive Director, stated that Staff D had not completed specialized training for mental illness. Staff A further stated they were not aware that nurses were required to complete specialized training.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) <u>8/07/23</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
 Administrator (or Representative)	<u>7/11/23</u> Date

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that specialized training for dementia was completed for 1 of 6 staff (Staff D). This failed practice placed 23

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residents diagnosed with dementia at risk of improper care by untrained staff.

Findings included...

Review of the undated personnel file for Staff D, Health and Wellness Director, showed no documentation for specialized training for dementia (memory impairment).

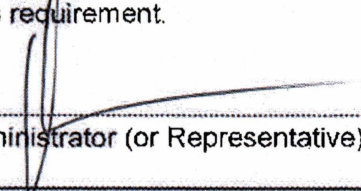
Review of the facility's undated Resident Characteristics Roster showed there were 23 residents with a dementia diagnosis.

In an interview on 06/14/2023 at 3:18 PM, Staff A, Area Executive Director, stated Staff D had not completed specialized training for dementia. Staff A further stated they were not aware that nurses were required to complete specialized training.

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, South Hill Village, Assisted Living & Memory Care is or will be in compliance with this law and / or regulation on (Date) 8/07/23.

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


Administrator (or Representative)

7/11/23
Date