



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
3117 E Chaser Lane
Spokane, WA 99223

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

Dear Administrator:

This letter addresses Compliance Determination(s) 58995 (Completion Date 05/02/2025) and 55781 (Completion Date 03/06/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/02/2025 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-2240

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor

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

Sincerely,

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

This document was prepared by Residential Care Services for the Locator website.



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 # 55781
Plan of Correction	South Hill Village, Assisted Living & Memory Care	Completion Date
Page 1 of 3	Licensee: PSL Associates, LLC	03/06/2025

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 03/05/2025 and 03/06/2025 of:

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

This document references the following SOD dated: 03/06/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 95 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licenser
Joy Pipgras, LTC Surveyor

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

This document was prepared by Residential Care Services for the Locator website.

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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.

J. Salquist
Residential Care Services

03/13/2025

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.

Kari Miller
Administrator (or Representative)

3/17/25
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that medications were available to be administered as ordered for 1 of 4 residents (Resident 16). This failure resulted in Resident 16 not receiving their medication for 4 days and placed the resident at risk of infection.

Review of Resident 16's Face Sheet showed a move in date of [REDACTED]/2024 and that the resident had diagnoses of [REDACTED] and [REDACTED].

Review of Resident 16's Negotiated Service Plan, dated 02/11/2025, showed the resident required assistance with medication administration.

Review of Resident 16's March 2025 Medication Administration Record showed the resident had an order for Septra (antibiotic for infection prevention) to be given once daily. Further review showed the resident did not receive the medication from 03/03/2025 - 03/06/2025, with documentation stating that the medication was not ordered in time and was not available.

Observation on 03/06/2025 at 9:45 AM, showed Staff Q, Medication Technician, unsuccessfully attempt to locate Resident 16's Septra. In an interview at that time, Staff Q confirmed that the

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for 4 days.

In an interview on 03/06/2025 at 12:45 PM, Staff P, Health and Wellness Director/RN, stated that staff had not reported that Resident 16 had not received their Septra for four days.

This is an uncorrected deficiency previously cited on 01/15/2025.

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) 4/20/25.

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

Kari M
Administrator (or Representative)

3/17/25
Date



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

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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 01/02/2025, 01/03/2025, 01/07/2025, 01/08/2025, 01/09/2025, 01/10/2025, 01/13/2025 and 01/14/2025 of:
South Hill Village, Assisted Living & Memory Care
3117 E Chaser Lane
Spokane, WA 99223

This document references the following complaint numbers: 158456.

The following sample was selected for review during the unannounced on-site visit: 15 of 99 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Brian Zbylski, ALF Licenser
Tethra Wales, Assisted Living Facility Licenser
Joy Pipgras, LTC Surveyor
Patricia Eddy, Community Licenser

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

This document was prepared by Residential Care Services for the Locator website.

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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.

J. Salquist
Residential Care Services

01/28/2025
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.

Kari Miller
Administrator (or Representative)

1/31/25
Date

WAC 388-78A-2210 Medication services.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received their medication as prescribed for 1 of 9 sampled residents (Resident 15). This failure contributed to the Resident 15 developing symptoms and requiring treatment and admission to the hospital.

Findings included...

Review of Resident 15's Negotiated Service Plan, dated 09/24/2024, showed the resident had a diagnosis of [REDACTED] and required assistance with medication administration.

Review of physician orders, dated 10/18/2024, showed that Resident 15 had an order for furosemide once daily (medication used to treat heart failure by decreasing fluid build-up in the lungs that causes shortness of breath).

Review of Resident Notes (progress notes), dated 01/10/2025, showed that Resident 15 was transported to the hospital via ambulance due to shortness of breath.

This document was prepared by Residential Care Services for the Locator website.

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Review of hospital admission records showed that Resident 15 presented to the emergency department on [REDACTED]/2025 with a complaint of shortness of breath that had increased over the past several days. Further review showed the resident reported only being able to walk short distances without taking a rest.

Review of hospital chest x-ray results, conducted on [REDACTED]/2025, showed Resident 15 had pulmonary vascular congestion (lung congestion that commonly causes shortness of breath). The record showed that Resident 15 was given furosemide in the emergency room to treat it.

Review of Resident 15's Medication Administration Record (MAR) showed that the furosemide was discontinued on 01/05/2025 and not administered to the resident from 01/06/2025 - [REDACTED]/2025, a total of five missed doses.

In an interview on 01/13/2025 at 11:25 AM, Staff J, Regional Health and Wellness Director, stated that Resident 15 was recently sent to the hospital due to shortness of breath, and had not been discharged yet. Staff J further stated that the resident's furosemide was discontinued from the MAR in error by Staff L, Resident Care Coordinator, without a provider order on 01/05/2025 and the resident did not receive the medication for several days.

In an interview on 01/13/2025 at 3:06 PM, Collateral Contact 5 (CC5), Resident Representative) stated that Resident 15 was currently in the hospital due to not receiving a "critical medication" for several days. CC5 further stated that they were concerned for the resident's safety if they came back to the facility.

This is a recurring deficiency previously cited on 06/23/2023 and 03/15/2024 for subsection (2)(a).

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) 3/1/25.

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

Administrator (or Representative)

Kari Min Date 1/31/25

This document was prepared by Residential Care Services for the Locator website.

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WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(6) Ensure:

(a) Individuals participating in developing the resident's negotiated service agreement:

(i) Discuss the resident's assessed needs, capabilities, and preferences; and

(ii) Negotiate and agree upon the care and services to be provided to support the resident; and

(b) Staff persons document in the resident's record the agreed upon plan for services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update a resident's negotiated service agreement following a change to the resident's mental and emotional needs for 1 of 14 residents (Resident 8) and failed to provide residents the opportunity to discuss, negotiate and come to agreement about their plan of care for 6 of 14 residents (Resident 3, 9, 10, 11, 12, and 13). This failure placed Resident 8 at risk of unmet mental and emotional needs and uninformed care, and prevented Residents 3, 9, 10, 11, 12, and 13 from participating in the planning of their services.

Findings included...

<Resident 8>

Review of Resident 8's Negotiated Service Plan (the facility's negotiated service agreement, NSA) dated [REDACTED]/2024 showed chronic illnesses of persistent depressive disorder (a continuous, long-term form of depression) and adjustment disorder with depressed mood (a mental disorder characterized by excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior). Further review showed no interventions or services related to the resident's mental or emotional health.

Review of Resident 8's Resident Notes (progress notes) dated 11/29/2024 showed the resident made suicidal comments in front of an outside provider and facility staff including "I just want to die" and "I want to die every damn day. I am useless."

Record review of Resident 8's NSA on 01/10/2025 showed that it had not been updated since the [REDACTED]/2024 NSA to reflect the resident's suicidal comments and provide care staff with interventions if there was a recurrence.

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In an interview on 01/10/2025 at 11:47 AM, Staff J, Regional Health and Wellness Director, stated that the NSA dated [REDACTED]/2024 was the current NSA. Staff J further stated that no updates were made to the NSA and no temporary service plans or interventions were put in place following the incident.

<Resident NSA Participation>

Review of the facility's "Resident Handbook Pegasus Senior Living" dated 05/2024, showed that "Regular meetings will be held with you, those representing you and all key community associates to discuss your individual service needs and preferences."

In an interview on 01/08/2025 at 3:23 PM, Staff P, Business Office Manager, stated that NSAs are often mailed to the residents' representatives. When asked by the department why NSAs were provided to the representatives for residents who were capable of participating in the care conference on their own behalf, Staff P stated the [previous] nurse provided them to the representatives.

In an interview on 01/08/2025 at 4:00 PM, Staff J stated that they set up care conferences with residents or their representatives and review the NSA. When asked how they document that the care conferences took place, Staff J stated the residents' signatures and dates on the NSA were the only documentation they kept. Staff J confirmed that they did not have signatures or dates on the NSAs for any of the sampled residents.

Resident 3

Review of Resident 3's NSA, dated 9/27/2024, showed the resident was oriented to time and self (no diagnoses of cognitive deficits or memory loss).

In an interview on 01/08/2025 at 1:30 PM, Resident 3 stated they had not had any conversations with facility staff regarding their NSA.

In an interview on 01/08/2025 at 2:52 PM, Collateral Contact 1 (CC1, Resident Representative) stated that they had received the resident's NSA. CC1 stated they contacted the facility multiple times to discuss concerns about Resident 3's care, which were never addressed.

Resident 9

Review of Resident 9's NSA, dated 10/02/2024, showed the resident had mild confusion.

In an interview on 01/08/2025 at 11:11 AM, CC2, Resident Representative, stated that they had not had any conversations with any facility staff regarding Resident 9's care plan.

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In an interview on 01/08/2025 at 1:15 PM, Resident 9 stated that they had not had any conversations with any facility staff regarding their care plan.

Resident 10

Review of Resident 10's NSA, dated 09/07/2024, showed the resident was oriented to time and self (no diagnoses of cognitive deficits or memory loss).

In an interview on 01/09/2025 at 12:00 PM, Resident 10 stated they had not had any conversations with any facility staff regarding their care plan since they were admitted on [REDACTED]/2023.

Resident 11

Review of Resident 11's NSA, dated 09/15/2024, showed the resident was oriented to time and self (no diagnoses of cognitive deficits or memory loss).

In an interview on 01/09/2025 at 10:30 AM, Resident 11 stated they had not had any conversations with any facility staff regarding their care plan since they were admitted on [REDACTED]/2022.

Resident 12

Review of Resident 12's NSA, dated 09/12/2024, showed the resident was oriented to person, place and time and was "very detail oriented."

In an interview on 01/08/2025 at 2:00 PM, Resident 12 stated that Staff N, Licensed Nurse, spoke to them regarding their most recent NSA. Resident 12 further stated that Staff N and left their apartment before they had a chance to completely review the NSA and have their questions addressed. The resident stated they were upset because they did not think the NSA was accurate.

Resident 13

Review of Resident 13's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2015.

Review of Resident 13's NSA, dated 08/04/2024, showed the resident is oriented to person, place and time (no diagnoses of cognitive deficits or memory loss).

In an interview on 01/08/2025 at 12:33 PM, Resident 13 stated that the only conversation they recalled related to their care was with Staff N, who told them that

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additional services were being added to their NSA. Resident 13 further stated that they disagreed that the additional services were needed, and that Staff N told them that the changes were not negotiable. Resident 13 stated that the conversation was limited to the additional services and did not include a discussion about their NSA.

Review of Resident 13's NSA dated 08/04/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

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) 3/1/25.

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

Kari Miller
Administrator (or Representative)

1/31/25
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

- (1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;
- (2) Determine the circumstances of the event;
- (3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
- (4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate, document investigative findings, and take action to protect residents for 2 of 3 residents (Resident 14 and 6). These failures resulted in Resident 14 feeling defenseless around the alleged staff and placed residents at risk of physical and psychosocial harm.

Findings included...

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<Resident 14>

Review of Resident 14's Negotiated Service Plan (the facility's titled negotiated service agreement, NSA), dated 09/16/2024, showed the resident was oriented to situation, time, place, and person (no diagnoses of cognitive deficits or memory loss), was able to make their needs known, and request assistance when needed.

In an interview on 01/03/2025 at 3:13 PM, Resident 14 stated that on 09/25/2024, Staff D, Care Partner, entered their room, took their cell phone and call pendant, placed something in front of their face that made them feel "woozy", and held them down before asking if they were ready to dress for breakfast. Resident 14 stated they called out for someone to call the police several times, but no one responded. Resident 14 further stated that they told Staff G, the previous Administrator, about the incident. Resident 14 stated that they were not asked any additional questions or spoken with about the incident by anyone in administration. Resident 14 further stated that Staff D was moved to a different floor following the incident. Resident 14 stated that they felt "defenseless" due to a previous stroke and that they had called care partners several times since the incident and asked them to check their room to make sure no one was there.

In an interview on 01/09/2025 at 1:30 PM, Staff M, Care Partner, stated that there was an incident between Resident 14 and Staff D several months ago. Staff M stated that Resident 14 told them that Staff D took their pendant away, was hovering over them, held them down, and made sure they didn't move. Staff M stated that Resident 14 told them about the incident several days in a row and that the facts remained consistent with each telling. Staff M stated that they were under the impression that Staff G, previous Administrator, and Staff N, previous Licensed Nurse, were aware of the situation because Staff D was moved to a different floor and the incident was brought up in a meeting with care staff between shifts. Staff M stated that they have never been approached or interviewed by administration about the incident.

In an interview on 01/09/2025 at 3:24 PM, Collateral Contact 4 (CC4, Resident Representative), stated they informed the facility about allegations Resident 14 made on 09/25/2024 about a staff member locking the resident in their room. CC4 further stated that a nurse spoke with them about the allegations but that they never received any additional communication from the facility.

Review of Resident 14's September, October, November, and December 2024 Resident Notes (progress notes) showed no notes related to the resident's allegation, the facility's conversation with the resident or the representative, or that the facility initiated an investigation to rule out abuse.

In an interview on 01/08/2025 at 1:54 PM, Staff J, Regional Health and Wellness Director, stated they did not have any incident reports for Resident 14 from September 2024 through 01/08/2025.

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In an interview on 01/09/2025 at 3:38 PM, Staff J confirmed there was no investigation conducted at the time of the incident and that an investigation was opened on 01/08/2025.

<Resident 6>

Review of Resident 6's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Review of a Resident Note (progress note) dated 12/29/2024 by Staff L, Resident Care Coordinator, showed documentation that "Staff reported a discolored skin abnormality in the shape of three fingers on Resident 6." There were no additional notes to show where the bruising was located, that a supervisor was notified, that they talked to the resident or their representative, or initiated an investigation to rule out abuse.

In an interview on 01/03/2025 at 1:35 PM, Staff J stated that they were not aware of the incident. Staff J stated they had not investigated to rule out abuse.

In an interview on 01/03/2025 at 2:00 PM, Staff J stated that they received an email from Staff L about the bruising sent on 12/29/2024 and had not read it.

In an interview on 1/10/2025 at 12:15 PM, Staff L stated that the incident occurred on 12/27/2024 and that care staff wrote an incident report at that time. Staff L further stated that they were not scheduled to work on 12/27/2024 and 12/28/2024 and did not see the incident report until 12/29/2024. Staff L then documented the incident and notified Staff J of the bruising via email.

In an interview on 01/07/2025 at 9:50 AM, Staff J stated that they had initiated their investigation on 01/03/2025 (7 days later) after being notified by the Department. Staff J stated they had completed their investigation and found a small area with yellow discoloration on Resident 6's right shoulder.

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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) 3/1/25.

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

Kari Miller
Administrator (or Representative)

1/31/25
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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report incidents of alleged abuse to the Complaint Resolution Unit for 2 of 4 residents (Resident 6 and 14). This failure delayed the department's ability to investigate the alleged abuse and placed residents at risk for physical abuse and psychosocial harm.

Findings included...

Review of the facility's Abuse and Neglect Reporting Guidelines, revised 11/01/2024, stated if abuse is suspected, staff are to act immediately to protect the resident from additional harm, call the supervisor as soon as possible, follow state regulations on reporting, initiate an investigation, and interview the resident(s).

<Resident 14>

Review of Resident 14's Negotiated Service Plan (the facility's titled negotiated service agreement, NSA), dated 09/16/2024, showed the resident was oriented to situation, time, place, and person (no diagnoses of cognitive deficits or memory loss), was able to make their needs known, and request assistance when needed.

In an interview on 01/03/2025 at 3:13 PM, Resident 14 stated that on 09/25/2024, Staff D, Care Partner, entered their room, took their cell phone and call pendant, placed

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something in front of their face that made them feel "woozy", and held them down before asking if they were ready to dress for breakfast. Resident 14 stated they called out for someone to call the police several times, but no one responded. Resident 14 further stated that they told Staff G, the previous Administrator, about the incident. Resident 14 stated that they were not asked any additional questions or spoken with about the incident by anyone in administration. Resident 14 further stated that Staff D was moved to a different floor following the incident. Resident 14 stated that they felt "defenseless" due to a previous stroke and that they had called care partners several times since the incident and asked them to check their room to make sure no one was there.

In an interview on 01/09/2025 at 1:30 PM, Staff M, Care Partner, stated that there was an incident between Resident 14 and Staff D several months ago. Staff M stated that Resident 14 told them that Staff D took their pendant away, was hovering over them, held them down, and made sure they didn't move. Staff M stated they did not report the allegations to the Complaint Resolution Unit or administration. Staff M stated that they were under the impression that Staff G, previous Administrator, and Staff N, previous Licensed Nurse, were aware of the situation because Staff D was moved to a different floor and the incident was brought up in a meeting with care staff between shifts.

In an interview on 01/09/2025 at 3:24 PM, Collateral Contact 4 (CC4, Resident Representative) stated they informed the facility about allegations Resident 14 made on 09/25/2024 about a staff member locking the resident in their room.

In an interview on 01/09/2025 at 3:39 PM, Staff J, Regional Health and Wellness Director, stated they were unaware of any incidents involving Resident 14. Review of the Department's Complaint Resolution Unit's (CRU) database on 01/03/2025 showed no facility reports to the CRU related to Resident 14's allegations.

<Resident 6>

Review of Resident 6's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024 and had a diagnosis of [REDACTED]

Review of Resident 6's NSA showed that the resident needed one to two person staff assistance with all cares and used an alphabet board to point to letters to make words for communication.

Review of a Resident Note (progress notes) dated 12/29/2024 by Staff L, Resident Care Coordinator, showed documentation that "Staff reported a discolored skin abnormality in the shape of three fingers on Resident 6." There were no additional notes documented as to where the bruising was located, that a supervisor was notified, or that a report was made to the Complaint Resolution Unit (CRU).

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In an interview on 01/03/2025 at 1:35 PM, Staff J stated that they were not aware of the incident and had not read an email sent by Staff L regarding the incident. Staff J stated they had not investigated to rule out abuse or reported the bruising to the CRU.

In an interview on 01/07/2025 at 9:50 AM, Staff J stated that they had finished the investigation, 11 days after the first observation of the bruising on 12/27/2024, and found a small area with yellow discoloration on Resident 6's right shoulder.

Review of the investigation report completed on 11/06/2024 (dated in error, correct date should read 01/06/2025), showed that that Staff I, Care Partner, first noticed the bruise, wrote the incident report and notified Staff O, Resident Services Director, on 12/27/2024.

In an interview on 01/10/2025 at 11:47 AM, Staff J stated that all facility staff are mandated reporters, and all staff received this training during orientation.

In an interview on 01/10/2025 at 12:15 PM, Staff L stated that the bruising was first noticed on 12/27/2024 and that care staff wrote an incident report at that time. Staff L further stated that they did not work for two days and did not see the incident report until 12/29/2024. Staff L further stated that they documented the incident and notified Staff J of the bruising via email. Staff L stated that they did not call the CRU as their understanding of the reporting process was to notify Staff J via email.

Review of the Department's Complaint Resolution Unit's (CRU) database on 01/03/2025 showed no facility reports to the CRU related to Resident 6's allegations.

This is a recurring deficiency previously cited on 06/23/2023 for subsection (1)(a).

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) 3/1/25.

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

Administrator (or Representative) Kari Miller Date 1/31/25

This document was prepared by Residential Care Services for the Locator website.

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WAC 388-78A-2474 Training and home care aide certification requirements.

- (3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.
- (4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure completion of facility orientation for 1 of 4 sampled staff (Staff B) and failed to ensure 4 of 6 staff (Staff C, D, F, and H) sampled for Department of Health credentials, had obtained their professional licenses or registrations. This failure placed the residents at risk of receiving care from unqualified individuals.

Findings included...

<Staff B>

Review of personnel records for Staff B, Care Partner/Med Aide, showed a hire date of 05/14/2024. The record review did not show documentation that facility orientation had been completed (241 days after hire).

In an interview on 01/10/2025 at 9:50 AM, Staff J, Regional Health and Wellness Director, stated that the facility did not have records to show Staff B completed facility orientation upon hire.

<Staff C>

Review of personnel records for Staff C, Care Partner, showed a hire date of 07/27/2023. The record review did not show documentation that basic training had been completed or record of home care aide (HCA) certification or Nursing Assistant Registration (NAR) (533 days after hire).

In an interview on 01/10/2025 at 9:50 AM, Staff J stated that Staff C had not completed basic training and did not have their HCA certification or NAR.

<Staff D>

Review of personnel records for Staff D, Care Partner/Med Aide, showed a hire date of 03/20/2024. The record review did not show a record of HCA certification or NAR (296 days after hire).

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In an interview on 01/10/2025 at 9:50 AM, Staff J stated that Staff D was currently working in the facility as a Med Aide, was enrolled in an HCA course but did not have their HCA certification or NAR.

<Staff F>

Review of personnel records for Staff F, Care Partner, showed a hire date of 08/03/2022. The record review did not show a record of HCA certification or NAR (891 days after hire).

In an interview on 01/10/2025 at 9:50 AM, Staff J stated that Staff F was enrolled in an HCA course but did not have their HCA certification or NAR.

<Staff H>

Review of personnel records for Staff H, Care Partner/Med Aide, showed a hire date of 05/02/2023. The record review did not show a record of HCA certification or NAR (619 days after hire).

Observation on 01/10/2025 at 2:30 PM, Staff H was observed giving medication to a resident in their room. At that time, Resident 12 stated that Staff H frequently brought them their medications.

In an interview on 01/10/2025 at 3:32 PM, Staff H stated that they had been working as a Med Aide at the facility for 7 or 8 months. Staff H further stated that they had not completed their HCA training and did not have their NAR.

In an interview on 01/10/2025 at 11:46 AM, Staff J stated that Staff H did not have their HCA certification or NAR.

In an interview on 01/10/2025 at 3:04 PM, Staff K, Assistant Executive Director, stated they were not aware of the timeline of care staff needing certifications.

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

Kari Miller
Administrator (or Representative)

1/31/25
Date

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff had completed developmental disability training for 3 of 3 staff (Staff B, C, and D) sampled for specialty training. This failure resulted in Resident 5 receiving care from individuals who had not completed their specialty training.

Findings included...

Review of the resident characteristic roster, provided to the department on 01/02/2025, showed Resident 5 was identified as developmentally disabled.

Review of Resident 5's Face Sheet showed an admission date of [REDACTED]/2020 and diagnoses of [REDACTED] and [REDACTED].

In an interview on 01/03/2025 at 11:15 AM, Staff J, Regional Health and Wellness Director, confirmed that Resident 5 was developmentally disabled.

<Staff B>

Review of personnel records for Staff B, Care Partner/Med Aide, showed a hire date of 05/14/2024.

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Further review showed that Staff B's records did not include specialized training for developmental disabilities.

<Staff C>

Review of personnel records for Staff C, Care Partner, showed a hire date of 07/27/2023.

Further review showed that Staff C's records did not include specialized training for developmental disabilities.

<Staff D>

Review of personnel records for Staff D, Care Partner/Med Aide, showed a hire date of 03/20/2024.

Further review showed that Staff D's records did not include specialized training for developmental disabilities.

In an interview on 01/10/2025 at 9:50 AM, Staff J stated that no staff persons had completed specialized training for developmental disabilities.

In an interview on 01/10/2025 at 3:04 PM, Staff K, Assistant Executive Director, stated they were not aware of the timeline for specialized trainings.

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) 3/1/25.

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

Kari Miller
Administrator (or Representative)

1/31/25
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

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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
 - (d) A licensed psychologist.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff had completed mental health training for 2 of 3 staff (Staff C and D) sampled for specialty training. This failure resulted in residents receiving care from individuals who had not completed their mental health training.

Findings included...

Review of the facility's undated Disclosure of Services showed that they provided care and services to residents with [REDACTED] diagnoses.

Review of the resident characteristic roster, provided to the department on 01/02/2025, showed that three residents received [REDACTED] services.

<Staff C>

Review of personnel records for Staff C, Care Partner, showed a hire date of 07/27/2023.

Further review showed that Staff C's records did not include specialized training for mental health.

<Staff D>

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Review of personnel records for Staff D, Care Partner/Med Aide, showed a hire date of 03/20/2024.

Further review showed that Staff D's records did not include specialized training for mental health.

In an interview on 01/10/2025 at 9:50 AM, Staff J, Regional Health and Wellness Director, stated that Staff C and D had not completed specialized training for mental health.

In an interview on 01/10/2025 at 3:04 PM, Staff K, Assistant Executive Director, stated they were not aware of the timeline for specialized trainings.

This is a recurring deficiency previously cited on 06/23/2023 for subsection (1)(2)(a)(b)(c)(d).

Plan/Attestation Statement	
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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Kari Miller</u> Administrator (or Representative)	<u>1/31/25</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 staff had completed dementia training for 1 of 3 staff (Staff C) sampled for specialty training. This failure resulted in residents receiving care from individuals who had not completed their

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dementia training.

Findings included...

Review of the facility's undated Disclosure of Services showed that they provided care and services to residents with [REDACTED] diagnoses.

Review of the resident characteristic roster, provided to the department on 01/02/2025, showed that 34 residents identified as having "Dementia/Alzheimer's/Cognitive impairment."

Review of personnel records for Staff C, Care Partner, showed a hire date of 07/27/2023.

Further review showed that Staff C's records did not include specialized training for dementia.

In an interview on 01/10/2025 at 9:50 AM, Staff J, Regional Health and Wellness Director, stated that Staff C and D had not completed specialized training for mental health.

In an interview on 01/10/2025 at 3:04 PM, Staff K, Assistant Executive Director, stated they were not aware of the timeline for specialized trainings.

This is a recurring deficiency previously cited on 06/23/2023.

Plan/Attestation Statement

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

Kari Miller
Administrator (or Representative)

1/31/25
Date

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WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medications were available to be administered as ordered for 1 of 6 residents (Resident 6). This failure resulted in the resident not receiving their medication for 8 days and placed the resident at risk of heart complications.

Findings included...

Review of the facility's titled "Washington Family Assist with Medications Plan Policy" dated 10/2021 showed that the facility would order and provide the medication if the resident or responsible party did not provide the medication in the needed time frame.

Review of Resident 6's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Review of Resident 6's Negotiated Service Plan (the facility's identified Negotiated Service Agreement, NSA) dated [REDACTED]/2024 showed that the resident was to receive medication assistance by the facility. Further review showed that the family assisted in ordering and picking up medications and that the licensed nurse or medication technician would be responsible for re-ordering medications.

Review of the December 2024 Medication Administration Records showed that Resident 6 had not received their atorvastatin (medication for decreasing the risk of heart attack, stroke, and high cholesterol) from [REDACTED]/2024 to [REDACTED]/2024.

In an interview on 01/03/2024 at 2:00 PM, Staff J stated that family did not bring the atorvastatin with them upon admission, and that the facility did not obtain the medication until [REDACTED]/2024, eight days later.

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

Kari Miller

Administrator (or Representative)

1/31/25

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;
- (2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and
- (3) Any public or private case manager for the resident, if available.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that Negotiated Service Plans were signed by the resident or the resident's representative, a facility representative, or the Department of Social and Health Services case manager for 14 of 14 residents sampled for signatures (Residents 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, and 15). This failure placed residents at risk of unmet care needs and receiving services that were not agreed upon.

Findings included...

<Resident 3>

Review of Resident 3's Face Sheet showed that the resident admitted to the facility on [REDACTED] 2020.

Review of Resident 3's NSA, dated 09/27/2024, showed it was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

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In an interview on 01/08/2025 at 2:52 PM, Collateral Contact 1 (CC1, Resident Representative), stated they received Resident 3's NSA but did not sign it due to several discrepancies and concerns. CC1 stated they had contacted the facility several times to resolve the issues, but they were never resolved.

<Resident 9>

Review of Resident 9's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2018.

Review of Resident 9's NSA, dated 10/02/2024 showed the plan was not signed by the resident or their representative, a facility representative, or the Department of Social and Health Services case manager, to indicate agreement to the plan.

In an interview on 01/08/2025 at 11:11 AM, CC2, Resident Representative, stated they did not recall being sent Resident 9's NSA to review and sign.

<Resident 10 >

Review of Resident 10's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2023.

Review of Resident 10's NSA dated 09/07/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

In an interview on 01/09/2025 at 12:00 PM, Resident 10 stated that they had not been provided a copy of their NSA to sign.

<Resident 11>

Review of Resident 11's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2022.

Review of Resident 11's NSA dated 09/15/2024 showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

In an interview on 01/09/2025 at 10:30 AM, Resident 11 stated they had not been

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provided a copy of their NSA to sign.

<Resident 12>

Review of Resident 12's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2017.

Review of Resident 12's NSA dated 09/12/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

In an interview on 01/08/2025 at 2:00 PM, Resident 12 stated that they had not signed the current NSA because they had not finished discussing the details with Staff N, Nurse.

<Resident 1>

Review of Resident 1's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2023.

Review of Resident 1's Negotiated Service Plan (the facility's titled negotiated service agreement, NSA), dated 09/11/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 2>

Review of Resident 2's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2017.

Review of Resident 2's NSA, dated 09/12/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 4>

Review of Resident 4's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024.

Review of Resident 4's NSA, dated 01/03/2025, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to

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the plan.

<Resident 5>

Review of Resident 5's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2020.

Review of Resident 5's NSA, dated 12/23/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 7>

Review of Resident 7's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024.

Review of Resident 7's NSA, dated 09/10/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 8>

Review of Resident 8's Face Sheet showed that the resident admitted to the facility on [REDACTED]/24.

Review of Resident 8's NSA, dated [REDACTED]/2024 showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 13>

Review of Resident 13's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2015.

Review of Resident 13's NSA dated 08/04/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 14>

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Review of Resident 14's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2022.

Review of Resident 14's NSA dated 09/16/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

<Resident 15>

Review of Resident 15's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2023.

Review of Resident 15's NSA dated 09/24/2024, showed the plan was not signed by the resident or their representative, or a facility representative, to indicate agreement to the plan.

In an interview on 01/03/2025 at 3:45 PM, Staff J, Regional Health and Wellness Director, confirmed there were no resident, representative, facility staff or case manager signatures for any residents' Negotiated Service Plans.

This is a recurring deficiency previously cited on 06/23/2023 for subsection (1).

Plan/Attestation Statement

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(Date) 3/1/25.

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

Kari Miller
Administrator (or Representative)

1/31/25
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(a) Provide a minimum of three meals a day:

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(i) At regular intervals;

(ii) With no more than fourteen hours between the evening meal and breakfast, unless the assisted living facility provides a nutritious snack after the evening meal and before breakfast.

(b) Provide sufficient time and staff support for residents to consume meals;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident received three meals a day and eating assistance, for 1 of 1 sampled resident (Resident 6). This failure resulted in unmet nutritional needs and staff support services.

Findings included...

Review of Resident 6's Face Sheet showed that the resident admitted to the facility on [REDACTED]/2024 with a diagnosis of [REDACTED].

Review of Resident 6's Negotiated Service Plan (the facility's negotiated service agreement, NSA) dated [REDACTED]/2024 showed that the resident was to receive one-to-two-person assistance with all cares and used a communication board to point to letters to spell words. Further review showed that Resident 6 was to receive adequate food intake, meal delivery to their room, and one person staff assistance with eating.

Review of a Resident Note (the facility's titled progress note) dated 12/12/2024, showed documentation that the resident's representative notified staff that the resident did not receive their breakfast or dinner. The note further stated that it was confirmed by Staff L, Resident Care Coordinator, and Staff O, Resident Services Director, that Resident 6 had not received the meals.

Review of a Resident Note dated 12/15/2024, showed that at 9:50 AM, Resident 6 "was upset because no one had been in their room to assist them with getting ready for the day, and they had not received breakfast."

In an interview on 01/03/2025 at 2:00 PM, Staff K, Assistant Executive Director, stated that caregivers deliver meal trays to residents who eat in their rooms and that they were unaware that Resident 6 had not received meals.

In an interview on 01/10/2025 at 10:00 AM, Collateral Contact 3 (CC3, Resident Representative), stated that Resident 6 had missed meals during their stay. CC3 further stated that during a visit with Resident 6, date unrecalled, they waited for two hours for the resident to receive their dinner. When it did not arrive, CC3 had to locate a care

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giver to retrieve dinner for the resident.

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


Administrator (or Representative)

1/31/25
Date

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

- (1) An assisted living facility may permit a resident's family member to administer medications or treatments or to provide medication or treatment assistance, including obtaining medications or treatment supplies, to the resident.
- (2) The assisted living facility must disclose to the department, residents, the residents' legal representatives, if any, and if not the residents' representative if any, and to interested consumers upon request, information describing whether the assisted living facility permits such family administration or assistance and, if so, the extent of any limitations or conditions.
- (3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:
- (a) By name, the family member who will provide the medication or treatment assistance or administration;
 - (b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;
 - (c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;
 - (d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and
 - (e) Other information determined necessary by the assisted living facility.

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(4) The plan for family assistance with medications or treatments must be signed and dated by:

- (a) The resident, if able;
 - (b) The resident's representative, if any;
 - (c) The resident's family member responsible for implementing the plan; and
 - (d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.
- (5) The assisted living facility may, through policy or procedure, require the resident's family member to immediately notify the assisted living facility of any changes in the medication or treatment plans for family assistance or administration.
- (6) The assisted living facility must require that whenever a resident's family provides medication assistance or medication administration services, the resident's significant medications remain on the assisted living facility premises whenever the resident is on the assisted living facility premises.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a written plan for family assistance with obtaining and setting-up medications for 1 of 2 residents (Resident 5) sampled for a family plan. This failure placed Resident 5 at risk of medical complications if medications were not provided by the family.

Findings included...

Review of the facility's titled "Washington Family Assist with Medications Plan Policy" dated 10/2021 showed that if a resident was receiving family assistance with their medication the facility Family Assist with Medication Plan form should be completed.

Review of Resident 5's Face Sheet showed an admission date of [REDACTED]/2020 with diagnoses of [REDACTED] and [REDACTED].

Review of Resident 5's Negotiated Service Plan (the facility's titled Negotiated Service Agreement) dated 12/23/2024, showed that the resident was independent with taking medications and their representative obtained and set up their medication each week.

Review of Resident 5's undated medical chart did not contain a family plan with medications to ensure there was a system in place to monitor the medication, or how the resident was to receive medications if their family could not assist.

In an interview on 01/03/2025 at 10:45 AM, Staff J, Regional Health and Wellness Director, confirmed that there was not a Family Assist with Medication Plan for Resident 5.

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In an interview on 01/03/2025 at 11:20 AM, Collateral Contact 6, (CC6, Resident Representative) stated that they had not reviewed or signed a Family Assist with Medication Plan.

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>3/1/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Kari Munn</u> Administrator (or Representative)	<u>1/21/25</u> Date

WAC 388-78A-2390 Resident records. The assisted living facility must maintain adequate records concerning residents to enable the assisted living facility:

(2) To respond appropriately in emergency situations.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to maintain updated records for 1 of 15 residents (Resident 11). This failure resulted in the facility providing emergency personnel an outdated medication list for Resident 11 and placed residents at risk of not receiving continuity of care when they were transferred to the hospital.

Findings included...

Review of the facility's Resident Self-Management of Medications policy, dated 08/26/2021, showed the facility required that all residents' current medications were listed in their Medication Administration Record (MAR), including those that self-administered their medications. The policy further showed that updates to MARs should occur as residents received new orders and that the facility needed to ensure that current physician's orders were in the resident's chart.

Review of Resident 11's Negotiated Service Plan (the facility's negotiated service agreement, NSA), dated 09/15/2024, showed the resident was independent with medication administration.

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In an interview on 01/09/2025 at 10:30 AM, Resident 11 stated they went to the hospital in April 2024 by ambulance. The resident stated the facility staff provided paramedics with an outdated list of their medications.

Review of Resident 11's November 2024, December 2024, and January 2025 MARs showed two medications each month.

Review of a current medication list dated 01/09/2025 and signed by their primary provider showed their current medication regiment contained 12 medications.

In an interview on 01/09/2025 at 11:45 AM, Staff J, Regional Health and Wellness Director, stated that the facility should be reaching out to medical providers quarterly to confirm medications and that they had not done so. Staff J further stated they had been relying on residents to inform the facility of medication changes.

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) 3/1/25.

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


Administrator (or Representative)

1/31/25
Date

WAC 388-78A-2270 Resident controlled medications.

(2) The assisted living facility must allow a resident to control and secure the medications that he or she self-administers or self-administers with assistance if the assisted living facility assesses the resident to be capable of safely and appropriately storing his or her own medications and the resident desires to do so.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to allow the resident to control and secure an inhaler for 1 of 9 residents (Resident 10). This failure

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resulted in the resident not having access to their inhaler as prescribed.

Findings included...

Review of a document dated 09/05/2023, from Resident 10's physician to the facility, showed that they agreed to have the resident self-administer their inhaler.

Review of Resident 10's Negotiated Service Plan (the facility's negotiated service agreement, NSA), dated 09/07/2024, showed the resident was admitted to the facility on [REDACTED]/2023. The document showed the resident had a diagnosis of [REDACTED] and received medication assistance. The document further showed the resident was oriented to time and self (no diagnoses of cognitive deficits or memory loss).

In an interview on 01/09/2025 at 12:00 PM, Resident 10 stated that the facility had been providing medication assistance for all medications, except for their inhaler (a portable device for administering a medication which is to be breathed in), since admission. They further stated that "about 6-8 months ago", facility staff removed the inhaler from their possession and denied their request to continue self-administering the inhaler. The resident stated their physician confirmed they were able to self-administer the inhaler.

An observation on 01/09/2025 at 12:15 PM showed calendars that were taped to the Resident's cupboards. Each day was marked with an X to indicate they had used their inhaler.

In an interview on 01/10/2025 at 11:15 AM, Staff J, Regional Health and Wellness Director, reported they could not find any documentation regarding why the inhaler was removed from the resident's possession or why the resident could no longer self-administer the inhaler.

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In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Kari Munn</u> Administrator (or Representative)	<u>1/31/25</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.
- (4) Individual's sensory abilities, including:
- (a) Vision; and

(b) Hearing.

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- (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

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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 interview and record review, the facility failed to complete a full assessment within 14 days of admission for 1 of 3 residents (Resident 8). This failure placed the resident at risk of not receiving care that supported or aligned with their current needs.

Findings included...

Review of Resident 8's Face Sheet showed Resident 8 was admitted to the facility on [REDACTED]/2024.

Review of Resident 8's pre-admission assessment showed it was completed on 11/07/2024. Further review of the resident's records showed it did not contain a full assessment within 14 days after admission.

In an interview on 01/07/2025 at 2:45 PM, Staff J, Regional Health and Wellness Director, stated that they did not have a 14-day assessment for Resident 8 and that only a pre-admission assessment was completed.

This is a recurring deficiency previously cited on 06/23/2023 for subsections (1)(a)-(11)(c).

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<u>Kari Miller</u> Administrator (or Representative)	<u>1/31/25</u> Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete an annual self-medication assessment for 2 of 2 residents (Resident 10 and 11). This failure resulted in residents not being assessed to ensure they had the cognitive abilities to safely administer their own medication.

Findings included...

Per WAC 388-78A-2090 (2)(a) Full Assessment Topics, an assessment to determine if medication can be self-administered must be completed for all residents.

<Resident 10>

Review of the facility's Resident Self-Management of Medications policy, revised 08/26/2021, showed that if a physician has indicated on an order that a resident is capable of self-administration, the facility should conduct a medication self-administration assessment. The policy further stated that the medication self-administration assessment should be completed with each annual assessment.

Review of a document dated 09/05/2023, from Resident 10's physician to the facility, showed that they agreed to have the resident self-administer the inhaler.

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Review of Resident 10's Negotiated Service Plan (the facility's negotiated service agreement, NSA), dated 09/07/2024, showed the resident was admitted to the facility on [REDACTED] /2023. The NSA showed the resident had a diagnosis of [REDACTED] and received medication assistance.

In an interview on 01/09/2025 at 12:00 PM, Resident 10 reported the facility had been providing medication assistance for all medications except for their inhaler (a portable device for administering a medication which is to be breathed in) since admission. The resident reported their physician confirmed they were able to self-administer the inhaler.

In an interview on 01/10/2025 at 11:15 AM, Staff J, Regional Health and Wellness Director, reported they could not find a Medication Self-administration Assessment for Resident 10.

<Resident 11>

Review of Resident 11's NSA, dated 09/15/2024, showed the resident was independent with medication administration.

Review of Resident 11's medical records, showed an outdated Medication Self-administration Assessment that was completed on 08/18/2023.

In an interview on 01/10/2025 at 11:15 AM, Staff J reported the facility did not have an updated Medication Self-administration Assessment for Resident 11.

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