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) 40795 (Completion Date 05/03/2024) and 37914 (Completion Date 03/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/03/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Anne Sinclair, NCI Community Complaint Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: South Hill Village, Assisted Living & Memory Care
Provider Type: Assisted Living Facility
License/Cert.#: 2480
Intake ID: 120360
Compliance Determination #: 37914
Region/Unit #: RCS Region 1 / Unit B
Investigator: Anne Sinclair
Investigation Date(s): 03/07/2024 through 03/15/2024
Complainant Contact Date(s): 03/04/2024, 03/14/2024

Allegation(s):

1. Resident medication not given as prescribed.

Investigation Methods:

Sample:	Total residents: 93 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Named Resident Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Named resident Residents Health and Wellness Specialist Resident Care Coordinator Regional Resident Care Coordinator Two Medtechs Private Caregiver
Record Reviews:	Named Resident care plan/face sheet Named Resident Medication Administration Record (January 2024-Current) Sample residents care plan/face sheet Sample Resident Medication Administration Record (January 2024-Current) Named Resident Treatment Administration Record Facility Medication Administration Policy Facility Abuse/Neglect reporting policy Disclosure of services Characteristic roster Staff roster

Investigation Summary:

1. Interview and record review showed named resident was not given a prescribed medication as ordered. Failed facility practice WAC 388-78A-2210(1)(b)(2)(a).

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

Statement of Deficiencies	License #: 2480	Compliance Determination # 37914
Plan of Correction	South Hill Village, Assisted Living & Memory Care	Completion Date
Page 1 of 4	Licensee: PSL Associates, LLC	03/15/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 03/07/2024, 03/07/2024 and 03/07/2024 of:

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

This document references the following complaint number(s): 120360

The following sample was selected for review during the unannounced on-site visit: 6 of 93 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anne Sinclair, NCI Community Complaint Investigator

RECEIVED
APR 11 2024
DSHS ALTSA RCS
SPOKANE VALLEY WA

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. [signature]
Residential Care Services

03/27/2024
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Emily Dixon
Administrator (or Representative)

4/11/2024
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide medications as prescribed for 1 of 6 sampled residents (Resident 1). This failure resulted in medication errors which contributed to elevated blood pressure for Resident 1 and placed the resident at risk of health complications due to not receiving the correct dose of medication based on physician orders.

Findings included...

The facility's undated policy titled, "Medication Services" stated, "Each resident who requires medication assistance will receive their medication as prescribed."

Review of Resident 1's Negotiated Service Agreement, dated 02/22/2024, showed that Resident 1 was diagnosed with [redacted] and required assistance with medication administration.

Review of Resident 1's January 2024 Medication Administration Record (MAR) showed that Resident 1 was prescribed losartan (blood pressure medication) one tab daily with instructions to increase the dose to two tabs daily if Resident 1's blood pressure measured over 140/90. Further review of the MAR showed no documentation to indicate an additional dose was given to Resident 1 based on prescription parameters (when the resident's BP was over 140/90).

Review of Resident 1's January 2024 Treatment Medication Record (TAR) showed Resident 1 was prescribed daily blood pressure checks. Further review of the TAR showed Resident 1's blood pressure measured over 140/90, 13 days in January, while prescribed losartan.

Review of Resident 1's February 2024 MAR showed Resident 1's losartan was given for 22 days and was discontinued on 02/22/2024. Further review of the MAR showed no documentation to indicate an additional dose of losartan was given to Resident 1 based on prescription parameters (when the resident's BP was over 140/90).

Review of Resident 1's February TAR showed Resident 1's blood pressure measured over 140/90, 13 days in February, while prescribed losartan.

In an interview on 03/02/2024 at 9:45AM, Collateral Contact 1 (CC1) stated that after they reviewed Resident 1's January and February 2024 MAR and TAR, they spoke with Staff A, Medication Tech, who informed them they had never given Resident 1 any extra doses of losartan after taking their blood pressure reading.

In an interview on 03/07/2024 at 9:55AM, Staff A stated they had not seen the parameters for the extra dose of losartan for Resident 1, had not given Resident 1 any extra doses related to daily blood pressure readings, and had told CC1 about having missed the medication parameters.

In an interview on 03/07/2024 at 10:35AM, Staff C, Resident Care Coordinator, verified that Resident 1 had been prescribed losartan medication on 01/16/2024 through 02/22/2024, and that the medication had blood pressure parameters for an extra dosage based on daily blood pressure reading.

In an interview on 03/07/2024 at 11:30AM, Staff B, Health and Wellness Director, stated that in reviewing Resident 1's January and February 2024 MAR and TAR, it "appeared there may have been medication errors related to losartan dosage and blood pressure parameters in the medication order."

In an email communication on 03/07/2024, Staff A stated they had clarified with Resident 1's physician related to the losartan order, and that Resident 1 should have received an additional 25mg tab of losartan when their systolic blood pressure (top number) was above 140 or their diastolic blood pressure was above 90.

This is a recurring 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) April 28, 2024 .

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

Emily Dixon — Administrator (or Representative)

4/11/2024 — Date