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

Callaway Gardens OpCo LLC
Callaway Gardens Alzheimers Special Care Center
5505 W Skagit Ct
Kennewick, WA 99336

RE: Callaway Gardens Alzheimers Special Care Center License # 2511

Dear Administrator:

This letter addresses Compliance Determination(s) 35045 (Completion Date 01/11/2024) and 31588 (Completion Date 12/04/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/11/2024 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-2300-3-a

The Department staff who did the on-site verification:
Sarah Clark, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Callaway Gardens Alzheimers Special Care Center
License/Cert.#: 2511
Compliance Determination #: 31588
Investigator: Sarah Clark
Investigation Date(s): 10/25/2023 through 12/04/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 102367
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A Named Resident (NR) aspirated at an appointment when they were to have had nothing by mouth.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident, Residents, Dining, Resident rooms, Staff to resident interactions, Resident to resident interactions
Interviews:	Identified resident, Residents, Facility Staff, Family members, others not associated with the facility
Record Reviews:	Resident Records, Facility policies, Incident investigation

Investigation Summary:
Interviews and record reviews showed that a NR was to not be fed after a documented time for a dental appointment. The NR did have food that caused them to have negative outcome at the appointment. Failed practice identified at 388-78A-2210 and 388-78A-2300. Reference Statement of Deficiencies dated 12/04/2023.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2511	Compliance Determination #:31598
Plan of Correction	Callaway Gardens Alzheimers Special Care Center	Completion Date
Page 1 of 6	Licensee: Callaway Gardens OpCo LLC	12/04/2023

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 10/26/2023 and 10/26/2023 of:

Callaway Gardens Alzheimers Special Care Center
5505 W Skagit Ct
Kennewick, WA 99338

This document references the following complaint number(s): 102367

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sarah Clark, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

J Salzquist
Residential Care Services

12/12/2023
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.

Laura Rupp
Administrator (or Representative)

12.22.23
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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement safe medication services when a resident was not supposed to receive any food or medication prior to a dental procedure for 1 of 1 resident (Resident 1). This failure contributed to Resident 1 aspirating (when food, liquid or saliva entering the lungs) during the dental procedure.

Findings included...

Review of ALF policy titled, "Communication of Resident Information," dated 11/01/2014, showed that the caregivers are responsible to read and be aware of each change on the Resident Service Plans [known as the Negotiated Service Agreement, NSA]. All Resident service plans will be placed in a 3-ring binger notebook. The notebooks will be placed in a central location that is easily accessible to all staff members. Each time there is a change in a Resident care approach or intervention, the change will be noted on a temporary service plan [Care In-Service/Change in Plan of Care Record] by a licensed nurse.

Review of Resident 1's Individual Service Plan (NSA), dated 07/14/2023, showed Resident 1 had a diagnosis of [redacted] It also showed that Resident 1 needed medication assistance and that Resident 1 would receive their medications safely.

Review of a 24-hour report sheet (documentation to notify staff), dated 10/11/2023, showed that Resident 1 was going out to dental appointment on [redacted]/2023 with pick up at 8:00 AM. "No food, No meds [medications]."

Review of a Resident Care In-Service/Change in Plan of Care Record (temporary service plan), dated 10/11/2023, was filled out by Staff A, Medication Technician, to show that Resident 1 was to be nothing by mouth (NPO) after 7:00 PM the night of [redacted]/2023 until after their appointment on [redacted]/2023.

Review of Resident 1's medication administration record on [redacted]/2023 showed that Resident 1 was given their morning medications in a small portion of pudding.

Review of Resident 1's hospital records showed that Resident 1 was admitted to the hospital from [redacted]/2023 through [redacted]/2023, with a diagnosis of [redacted] and treated with intravenous (in the vein) antibiotics.

During an interview on 10/25/2023 at 11:54 AM, Staff A, stated they were notified by Collateral Contact 1 (CC1), resident representative, on the afternoon of 10/11/2023, that Resident 1 had a scheduled dental appointment on [redacted]/2023 and Resident 1 needed to be NPO that night. Staff A said they wrote the communication on a bright orange Resident Care In-Service/Change in Plan of Care Record form and hung it at the nurse's station on the afternoon of 10/11/2023. Staff A stated they worked the day of Resident 1's dental appointment and they administered Resident 1 medications in a "spoonful" of pudding. Staff A also stated that staff are expected to do a change of shift report and to read the communication book/alert charting book before they start their shift.

During an interview on 12/4/2023 at 10:29 AM, Collateral Contact 2, Clinic Staff at dental office, stated they had called CC1 to remind them of Resident 1 status was to not receive food or medication (nothing by mouth) and CC1 had told them that they had let the ALF know, twice, of Resident 1 NPO status for the dental procedure.

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, Callaway Gardens Alzheimers Special Care Center is or will be in compliance with this law and / or regulation on (Date) Dec 19, 2023

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

Laura Rupp — Administrator (or Representative)

Dec 22, 2023 — Date

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

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a modified diet of nothing by mouth (NPO) as per the Resident Care In-Service/Change in Plan of Care Record (temporary service plan) prior to a dental appointment for 1 of 1 resident (Resident 1). This failure contributed to Resident 1 aspirating (when food, liquid or saliva entering the lungs) during the dental procedure.

Findings included…

Review of Assisted Living Facility (ALF) policy titled, Communication of Resident Information dated, 11/01/2014, showed that the caregivers are responsible to read and be aware of each change on the Resident Service Plans [known as the Negotiated Service Agreement, NSA]. The notebooks will be placed in a central location that is easily accessible to all staff members. Each time there is a change in a Resident care approach or intervention, the change will be noted on a temporary service plan [Care In-Service/Change in Plan of Care Record] by a licensed nurse.

Review of Resident 1's Individual Service Plan (NSA), dated 07/14/2023, showed Resident 1 had a diagnosis of [redacted] It also showed that Resident 1 was ambulatory without an assistive device and that during meals, Resident 1 needed cueing from staff to eat.

Review of a Resident Care In-Service/Change in Plan of Care Record (temporary service plan), dated 10/11/2023, was filled out by Staff A, Medication Technician, to show that Resident 1 was to be NPO after 7:00 PM the night of [redacted]/2023 until after their appointment on [redacted]/2023.

Review of a 24-hour report sheet (documentation to notify staff), dated 10/11/2023, showed that Resident 1 was going out to dental appointment on [redacted]/2023 with pick up at 8:00 AM. "No food, No meds [medications]."

Review of Resident 1's meal attendance record for [redacted]/2023 showed that breakfast intake was one hundred percent.

Per ALF's investigative document dated 10/17/2023 by Staff H, Caregiver, showed they were not aware that Resident 1 was not to have any food on [redacted]/2023.

Per ALF's investigative document dated 10/17/2023 by Staff I, Caregiver, showed on [redacted]/2023 they saw Resident 1 in the dining room and was also not aware that Resident 1 was not supposed to eat anything that morning.

Review of Resident 1's hospital records showed that Resident 1 was admitted to the hospital from [redacted]/2023 through [redacted]/2023, with a diagnosis of [redacted]

[redacted] and treated with intravenous (in the vein) antibiotics.

During an interview on 10/25/2023 at 11:08 AM, Staff B, Registered Nurse (RN) stated that staff are expected to read the 24-hour communication book and the Care In-Service/Change in Plan of Care Record before starting their shifts. Staff B also stated it was concerning to management to the lack of caregiver signatures on the Care In-Service/Change in Plan of Care Record form alerting staff of the temporary care plan changes for Resident 1.

During an interview on 10/25/2023 at 11:54 AM, Staff A, stated they were notified by Collateral Contact 1 (CC1), resident representative, on the afternoon of 10/11/2023, that Resident 1 had a scheduled dental appointment on [redacted]/2023 and Resident 1 needed to be NPO that night. Staff A said they wrote the communication on a bright orange Care In-Service/Change in Plan of Care Record form and hung it at the nurse's station on the afternoon of 10/11/2023. Staff A stated they worked the day of Resident 1's dental appointment and they administered Resident 1 medications in a "spoonful" of pudding. Staff A also stated that staff are expected to do a change of shift report and to read the communication book/alert charting book before they start their shift.

During an interview on 10/25/2023 at 11:57 AM, Staff C, Caregiver stated that they were the caregiver for Resident 1 on the day Resident 1 was to be NPO. Staff A also denied seeing any communication posted about Resident 1 being NPO and they did not receive a verbal report from the night shift staff.

During an interview on 10/25/2023 at 11:01 AM, Staff D, Health Services Director, stated that it was every caregiver's responsibility to be aware of the changes with all of the ALF residents, regardless if those residents are assigned to that staff member or not. Staff D also stated that caregivers do not serve plates up for meals, only dietary staff do that.

During an interview on 10/25/2023 at 12:36 PM, Staff F, Dietary Manager, they stated that they had received an NPO slip for Resident 1, hung it up in the kitchen and made their dietary staff aware of the communication.

During an interview on 11/08/2023 at 11:25 AM Staff E, Caregiver, confirmed they saw the resident eating. Staff E was not aware of who served Resident 1 a plate, as kitchen staff are the only ones who are to plate the food.

During an interview on 11/08/2023 at 4:05 PM, Collateral Contact (CC1), stated that when they went to pick up Resident 1, for the dentist appointment, they were told by an unnamed staff member that Resident 1 had not eaten anything. CC1 also stated that during the event CC1 was "frustrated and angry" that this happened to Resident 1 and "there was nothing I could do about it." CC1 stated they felt the facility had a breakdown or lack of communication, and that staff should be told of resident changes the first thing when they come onto their shift. CC1 also indicated that Resident 1 laid in the hospital for

six days and must have in-house therapy to get them to improve their strength to order to walk again.

During an interview on 12/4/2023 at 10:28 AM, Collateral Contact 2, Clinic Staff at dental office, stated they had called CC1 to remind them of Resident 1 NPO status and CC1 had told them that they had let the ALF know, twice, of Resident 1's NPO status for the dental procedure.

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, Callaway Gardens Alzheimers Special Care Center is or will be in compliance with this law and / or regulation on (Date) DEC 19, 2023

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

Laura Rupp
Administrator (or Representative)

Dec 22, 2023
Date