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

Summer Wood OpCo LLC
Summer Wood Alzheimer's Special Care Center
830 NW Sunburst Ct
Moses Lake, WA 98837

RE: Summer Wood Alzheimer's Special Care Center License # 2514

Dear Administrator:

This letter addresses Compliance Determination(s) 39454 (Completion Date 04/10/2024) and 36780 (Completion Date 02/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/10/2024 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-2170-1

The Department staff who did the on-site verification:
Sandra Fast, 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: Summer Wood Alzheimer's Special Care Center
Provider Type: Assisted Living Facility
License/Cert.#: 2514
Intake ID: 117505
Compliance Determination #: 36780
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 02/13/2024 through 02/15/2024
Complainant Contact Date(s):

Allegation(s):
Medication errors on two residents.

Investigation Methods:

Sample:
Total residents: 43
Resident sample size: 5
Closed records sample size: 0

Observations:
Named residents
Sample residents
Medication aid
Medication pass
Order processing
Lunch service
Kitchen and coffee area
Common areas, hallways and corridors
Resident apartments

Interviews:
Administrator
Health Services Director
Medication aids
Named residents
Sample residents
Resident representatives
Dietary Director

Record Reviews:
Disclosure of services
Characteristic roster
Staff roster
Staff background check
Staff education
Abuse and Neglect policy
Medication aid training
Alert Charting policy
Managing Medications policy
Processing Physicians Orders policy
Named residents' face sheets

Named residents' negotiated service plans
Named residents' individual service plans
Named residents' medication orders
Named residents' medication administration record
Sample residents' face sheets

Investigation Summary:

Two named residents continued receiving a prior medication after the facility had received physician's orders to discontinue the medication and start a different medication. Both medications remained on both residents' medication administration records for a prolonged period of time before being noticed. The facility failed to follow safe procedure for processing physician's orders. Failed facility practice was identified, and a statement of deficiency was issued based on WAC 388-78A-(2210)(1)(b).

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Wood Alzheimer's Special Care Center
Provider Type: Assisted Living Facility
License/Cert.#: 2514
Intake ID: 117520
Compliance Determination #: 36780
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sandra Fast
Investigation Date(s): 02/13/2024 through 02/15/2024
Complainant Contact Date(s):

Allegation(s):
A resident suffered burns after spilling a hot beverage in their lap.

Investigation Methods:

Sample:
Total residents: 43
Resident sample size: 5
Closed records sample size: 0

Observations:
Named residents
Sample residents
Medication aid
Medication pass
Order processing
Lunch service
Kitchen and coffee area
Common areas, hallways and corridors
Resident apartments

Interviews:
Administrator
Health Services Director
Medication aids
Named residents
Sample residents
Resident representatives
Dietary Director

Record Reviews:
Disclosure of services
Characteristic roster
Staff roster
Staff background check
Staff education
Abuse and Neglect policy
Medication aid training
Alert Charting policy
Managing Medications policy
Processing Physicians Orders policy
Named residents' face sheets

Named residents' negotiated service plans
Named residents' individual service plans
Named residents' medication orders
Named residents' medication administration record
Sample residents' face sheets

Investigation Summary:

A named resident who had a chronic condition which limited their capability to make safe choices, was given a hot beverage by a facility staff and sustained burns. The facility failed to ensure that the hot beverage was at a safe temperature before it was served to the resident. There was no system in place for monitoring or recording the hot beverage was at a safe temperature before dispensing it to residents. Failed facility practice was identified. A statement of deficiency was issued based on WAC 388-78A-(2170)(1).

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 #: 2514	Compliance Determination #36780
Plan of Correction	Summer Wood Alzheimer's Special Care Center	Completion Date
Page 1 of 4	Licensee: Summer Wood OpCo LLC	02/15/2024

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 02/13/2024, 02/13/2024 and 02/13/2024 of:

Summer Wood Alzheimer's Special Care Center
830 NW Sunburst Ct
Moses Lake, WA 98837

This document references the following complaint number(s): 117505, 117520

The following sample was selected for review during the unannounced on-site visit: 5 of 43 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sandra Fast, Community Complaint Investigator

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

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

S.M

Residential Care Services

02/27/2024
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.

Administrator (or Representative) — Date: 3/8/2024

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 interview and record review, the facility failed to implement a change in a health care provider's medication order for 2 of 2 residents (Resident 2 and 3). This failure resulted in the residents receiving a double dose of medication and placed residents at risk for a medication overdose.

Findings included...

Review of the facility's undated instruction sheet titled, "How to process physicians orders," showed that if staff were not clear about a medication order they were to clarify the order with the prescriber.

Review of a physician order, dated 01/12/2024, showed Resident 2's antipsychotic medication (a medication primarily used to manage psychosis, including delusions, hallucinations, paranoia or disordered thought) was discontinued on 01/13/2024 and a different antipsychotic medication was to be started. A review of Resident 2's medication administration record (MAR) showed the new antipsychotic medication was started on 01/13/2024 but the previous antipsychotic medication was not discontinued. The MAR showed the resident received the discontinued medication along with the new medication for 24 days.

Review of a physician order, dated 01/12/2024, showed Resident 3's antipsychotic was discontinued, and a different antipsychotic medication was to be started on 01/13/2024. Resident 3's MAR showed the new antipsychotic medication was started but the previous antipsychotic medication was not discontinued. The MAR showed the resident received the discontinued medication along with the new medication for 18 days.

In an interview on 02/13/2024 at 10:58 AM, Staff A, Administrator, stated that some medication aids had held Resident 3's discontinued medication and had documented that an order clarification was needed.

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, Summer Wood Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 3/29/2024 .

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

Jamie Ahmann
Administrator (or Representative)

3/8/2024
Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that hot coffee served measured below a safe temperature of 120 degrees Fahrenheit for 1 of 1 sampled resident (Resident 1) reviewed for a burn injury. This failure resulted in Resident 1 sustaining a burn and placed residents who have difficulty making safe choices at risk for harm from hot beverages.

Findings included...

Review of Resident 1's negotiated service plan, dated 08/25/2023, showed a chronic medical condition that affected decision making, impulsivity and safety awareness.

Review of Resident 1's temporary service plan, dated 02/04/2024, showed that Resident 1 sustained burns and blister to their inner thighs after spilling hot coffee (that had not been temperature checked) in their lap.

In an interview on 02/13/2024 at 10:58 AM, Staff A, Administrator, stated that a caregiver had dispensed hot coffee to a resident from an "air pot" that was not checked for temperature.

In an interview on 02/13/2024 at 1:08 PM, Staff C, Dietary Services Director stated the hot beverage in the air pot was temped at 150 degrees Fahrenheit (F). Staff C stated they were

not regularly temping or keeping any records of the temperature of hot beverages served to the residents. Staff C stated the hot beverage was being transferred to a carafe and was served to residents from the carafe.

An observation on 02/13/2024 at 1:08 PM showed a white carafe at the serving area with coffee inside. Staff C temped the coffee in the white carafe at 126 (F) after it had sat out without the lid on to cool.

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, Summer Wood Alzheimer's Special Care Center is or will be in compliance with this law and / or regulation on (Date) 3/29/2024 .

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

Jamie Abrams
Administrator (or Representative)

2/8/2024
Date