



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Van Vista Plaza LLLP
Van Vista Assisted Living
410 W 13th St
Vancouver, WA 98660

RE: Van Vista Assisted Living License # 2529

Dear Administrator:

This letter addresses Compliance Determination(s) 30901 (Completion Date 10/13/2023) and 27914 (Completion Date 08/16/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/13/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:

Jacob Ubl, ALF NCI CI

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services



Residential Care Services Investigation Summary Report

Provider/Facility: Van Vista Assisted Living **Provider Type:** Assisted Living Facility
License/Cert.#: 2529
Compliance Determination #: 27914 **Intake ID:** 92777
Investigator: Jacob Ubl **Region/Unit #:** RCS Region 3 / Unit I
Investigation Date(s): 08/09/2023 through 08/16/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of care/treatment: Allegation that the facility staff intentionally provided a resident food that they were allergic to.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Kitchen Food preparation
Interviews:	Identified resident staff Residents
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of care/treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for care, safety and services with no concerns. The facility has a system in place to ensure residents are delivered the food they ordered and food they are not allergic to. One staff member did not follow the facility's standard operating procedure on the day of the allegation concern resulting in the wrong food being delivered to the alleged victim.

Conclusion / Action:

- ☐ 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: Van Vista Assisted Living **Provider Type:** Assisted Living Facility
License/Cert.#: 2529
Compliance Determination #: 27914 **Intake ID:** 91608
Investigator: Jacob Ubl **Region/Unit #:** RCS Region 3 / Unit I
Investigation Date(s): 08/09/2023 through 08/16/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of care/treatment: Allegation that the facility staff are refusing to assist alleged victim with care needs and not providing medication services correctly.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions Resident rooms
Interviews:	Identified resident staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of care/treatment: Failed practice identified. Facility staff were not providing alleged victim's medication's as prescribed. Unable to substantiate that the facility staff were refusing to assist alleged victim with care needs.

Conclusion / Action:

- ☒ 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: Van Vista Assisted Living **Provider Type:** Assisted Living Facility
License/Cert.#: 2529
Compliance Determination #: 27914 **Intake ID:** 91156
Investigator: Jacob Ubl **Region/Unit #:** RCS Region 3 / Unit I
Investigation Date(s): 08/09/2023 through 08/16/2023
Complainant Contact Date(s):

Allegation(s):

1. Quality of care/treatment: Allegation that the facility staff are not providing alleged victim's medications as prescribed, not supporting the resident emotionally, and entering resident room without permission.

Investigation Methods:

Sample:	Total residents: 89 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Identified resident staff Residents
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of care/treatment: Failed practice identified. Facility staff were not providing alleged victim's medication's as prescribed. Unable to substantiate that the facility staff were not supporting the resident emotionally and entering resident room without permission.

Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2529	Compliance Determination # 27914
Plan of Correction	Van Vista Assisted Living	Completion Date
Page 1 of 4	Licensee: Van Vista Plaza LLLP	08/16/2023

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 08/09/2023 and 08/16/2023 of:

Van Vista Assisted Living
410 W 13th St
Vancouver, WA 98660

This document references the following complaint number(s): 92777, 91608, 91156

The following sample was selected for review during the unannounced on-site visit: 3 of 89 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit I
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.


Residential Care Services

08.24.2023

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.

Statement of Deficiencies	License #: 2529	Compliance Determination # 27914
Plan of Correction	Van Vista Assisted Living	Completion Date
Page 2 of 4	Licensee: Van Vista Plaza LLLP	08/16/2023

AS
Administrator (or Representative)

09.05.2023
Date

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

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

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

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide medications as ordered for 1 of 3 residents (Resident 1) reviewed for correct medication services. This failure resulted in the resident not receiving medications as prescribed and placed the resident at risk for health complications due to not receiving medications as prescribed.

Findings included...

During a complaint investigation visit on 08/09/2023 at 11:32 AM, Staff A, Medication Technician, reported that Resident 1 (R1) has an "as needed" (PRN) Potassium prescription (A mineral that is important for many body functions) that should be given as ordered with R1's PRN Furosemide prescription (A medication to help eliminate extra fluid being retained in the body). The Potassium prescription clearly states that those medications are always to be given together.

Review of facility policy titled, "Medication Services", "Revised 07/2009", regarding the facility's responsibility in medication administration, showed "The facility will assure medications are taken in accordance with the health care practitioner's instructions."

Review of an undated face sheet showed R1 was admitted to the facility on [REDACTED] 2021.

Statement of Deficiencies	License #: 2529	Compliance Determination # 27914
Plan of Correction	Van Vista Assisted Living	Completion Date
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Record review of R1's Negotiated Service Agreement, dated 03/09/2023, showed the facility was to assist with medications as prescribed.

Record review of R1's July 2023 Medication Administration Record (MAR) documented the medication Furosemide 20 MG (Milligram) Tablet "GIVE 1 TABLET BY MOUTH EVERY MORNING AS NEEDED FOR LEG SWELLING OR WEIGHT GAIN" and was scheduled for 2:00PM.

Record review of R1's July 2023 MAR, showed R1 was provided 12 doses of furosemide: 07/15/2023, 07/16/2023, 07/17/2023, 07/18/2023, 07/20/2023, 07/21/2023, 07/22/2023, 07/23/2023, 07/24/2023, 07/25/2023, 07/26/2023, and 07/27/2023.

Record review of R1's July 2023 MAR documented the medication Potassium 20 MEQ (Milliequivalents) Tablet "GIVE 1 TABLET BY MOUTH ONCE A DAY AS NEEDED WHEN TAKING FUROSEMIDE" and was scheduled for 2:00PM.

Record review of R1's July 2023 MAR, showed R1 was provided 3 doses of potassium: 07/22/2023, 07/23/2023, and 07/24/2023.

In an interview on 08/09/2023 at 11:47 AM, Staff B, Medication Technician, reported that R1's PRN potassium prescription should always be given with R1's PRN furosemide prescription as ordered because the instructions were for those medications to be given together.

In an interview on 08/09/2023 at 12:02 PM, Staff C, Medication Technician, reported that R1's PRN potassium prescription should have been given with R1's PRN furosemide prescription as ordered, and it is important for neither medication to be missed.

In an interview on 08/14/2023 at 2:50 PM, Staff D, Health Services Director, reported that R1's PRN potassium prescription should have been given with R1's PRN furosemide prescription every time, as ordered, but this was not being followed through with by staff. Staff D reported that, In the month of July, R1's PRN furosemide was given 12 times and R1's PRN potassium should have also been given all 12 times, but staff only followed through with giving the potassium 3 out of the 12 times, resulting in 9 missed potassium doses in July. Staff D reported that the facility failure to follow through with giving the potassium as prescribed to R1 was unacceptable and reported intentions to counsel staff that administer medications so that this mistake is not repeated.

In an interview on 08/15/2023 at 2:06 PM, R1 reported that the facility staff only sometimes remembered to give the potassium with their furosemide but most of the time forgot to provide the Potassium along with their furosemide.

In an interview on 08/16/2023 at 08:32 AM, Staff E, Executive Director, reported that

Statement of Deficiencies	License #: 2529	Compliance Determination # 27914
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facility staff mistakenly missed R1's potassium prescription 9 times in the month of July. Staff E reported the facility's expectation is for staff to follow through with providing residents their ordered medications as prescribed by their Primary Care Providers and it is unacceptable that staff did not give R1's potassium according to the prescription instructions.

This is a recurring deficiency previously cited on 01/20/2023, and 03/09/2023. for subsection 1(b) and 2(b).

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Van Vista Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~10-08-2023~~ 09.30.2023

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

LS
 Administrator (or Representative)

09.01.2023
 Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

08/24/2023

Van Vista Plaza LLLP
Van Vista Assisted Living
410 W 13th St
Vancouver, WA 98660

RE: Van Vista Assisted Living # 2529

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 08/16/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);
- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
 - o Sign and date the enclosed report;
 - o For each deficiency, indicate the date you have or will correct each deficiency;
 - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
 - o Mail the Plan/Attestation Statement and report with original signatures to:

Michael Burdick, Field Manager
Residential Care Services

Region 3, Unit I

800 NE 136th Ave Ste 200

Vancouver, WA 98684

- Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
- Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

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

- (1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;
- (3) Evaluate, in order to determine if there is a need for further action:
 - (a) The changes identified in the resident per subsection (2) of this section; and
 - (b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.
- (4) Take appropriate action in response to each resident's changing needs.

Staff failed to monitor a resident's well-being and acknowledged the failure to advocate for physician orders to clarify prescription parameters and needed frequency of weighing the resident. After the unannounced onsite investigation was initiated, the facility nurse contacted the resident's physician for clarity on diuretic prescription parameters and advocated for needed orders to monitor weight of resident to make it possible for facility to determine resident weight gain.

You Are Not:

- Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

- Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

- Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
 - o What specific deficiency or deficiencies you disagree with;
 - o Why you disagree with each deficiency; and
 - o Whether you want an IDR to occur in-person, by telephone or as a paper review.
 - o Send your request to:

Van Vista Assisted Living # 2529

08/16/2023

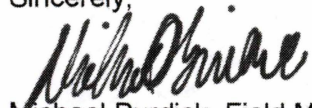
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IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (360)450-1218.

Sincerely,



Michael Burdick, Field Manager
Region 3, Unit I
Residential Care Services

Enclosure

Date: 09/01/2023

Re: Complaint Survey 08/09/2023 and 08/16/2023 – Statement of Deficiencies: Plan of Correction

WAC 388-78A-2210(1)(a)(b)(2)(a)(b)

Van Vista Assisted Living will ensure exemplary safety measures for safe medication services for those residents receiving medication assistance by staff.

- All clinical staff will attend an in-service meeting covering the following topics:
 - Review of WAC 388-78A-2210 (including all subsections).
 - Review of medication rights and responsibilities as medication aides.
 - Review of company policies regarding medication services.
- Two staff members will review all orders to ensure accurate and correct information.
- Weekly quality audit of medication orders by Lead Med Aides, Community Nurse, Resident Care Coordinator or Executive Director for 90 days.