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) 59691 (Completion Date 05/21/2025) and 55089 (Completion Date 03/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/21/2025 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-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b, WAC 388-78A-2240

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,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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
Intake ID: 167301
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Admission, Transfer, & Discharge Rights: Allegations that Facility is inappropriately discharging Resident Alleged Victim.

2. Quality of Care/Treatment: Allegations that Facility is not giving Resident Alleged Victim their medications on time.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Admission, Transfer, & Discharge Rights: No failed practice identified. Resident Alleged Victim voluntarily transitioning to another living setting.

2. Quality of Care/Treatment: Failed practice identified. The Facility failed to deliver residents medications on time.

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
Intake ID: 167212
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Dietary Services: Allegations that Facility was not appropriately accommodating Resident Alleged Victim's dietary needs.

2. Resident/Patient/Client Rights: Allegations that Facility staff were not treating Resident Alleged Victim with dignity and respect.

3. Administration/Personnel: Allegations that Facility staff were not providing care and services appropriately.

4. Quality of Care/Treatment: Allegations that Facility was not appropriately responding to Resident Alleged Victim's fall.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Dietary Services: 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.

2. Resident/Patient/Client Rights: 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.

3. Administration/Personnel: Failed practice identified. The Facility failed to deliver residents medications on time.

4. 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.

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: Van Vista Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2529
Intake ID: 167213
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Allegations that Facility is not appropriately addressing Resident Alleged Victims weight loss.

2. Pharmaceutical Services: Allegations that Facility is not giving Resident Alleged Victim their medications on time.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff
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.

2. Pharmaceutical Services: Failed practice identified. The Facility failed to deliver residents medications on time.

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: Van Vista Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2529
Intake ID: 166770
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Allegations that Facility is not giving Resident Alleged Victim their medications on time.

2. Nursing services: Allegations that Facility is not giving Resident Alleged Victim their medications.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident staff
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/Treatment: Failed practice identified. The Facility failed to deliver residents medications on time.

2. Nursing services: Failed practice identified. The Facility failed to make residents medication available.

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: Van Vista Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2529
Intake ID: 168169
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Pharmaceutical services: Allegations that Facility is not giving Resident Alleged Victim their medications on time.

2. Nursing services: Allegations that Facility is not giving Resident Alleged Victim their medications.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Pharmaceutical services: Failed practice identified. The Facility failed to deliver residents medications on time.

2. Nursing services: Failed practice identified. The Facility failed to make residents medication available.

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: Van Vista Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2529
Intake ID: 168235
Compliance Determination #: 55089
Region/Unit #: RCS Region 3 / Unit I
Investigator: Jacob Ubl
Investigation Date(s): 02/18/2025 through 03/21/2025
Complainant Contact Date(s):

Allegation(s):

1. Pharmaceutical services: Allegations that Facility is not giving Resident Alleged Victim their medications on time.

2. Quality of Care/Treatment: Allegations that Facility is not giving Resident Alleged Victim their medications.

3. Resident/Patient/Client Abuse: Allegations that Facility staff were not treating Resident Alleged Victim with dignity and respect.

Investigation Methods:

Sample:	Total residents: 90 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Pharmaceutical services: Failed practice identified. The Facility failed to deliver residents medications on time.

2. Quality of Care/Treatment: Failed practice identified. The Facility failed to make residents medication available.

3. Resident/Patient/Client Abuse: 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.

Conclusion / Action:

- [x] 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

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 02/18/2025 and 03/11/2025 of:

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

This document references the following complaint number(s): 167795, 167301, 167213, 167212, 166770, 168169, 168235

The following sample was selected for review during the unannounced on-site visit: 4 of 90 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

Statement of Deficiencies	License #: 3529	Compliance Determination #:55089
Plan of Correction	Van Vista Assisted Living	Completion Date
Page 2 of 11	Licensee: Van Vista Plaza LLLP	03/21/2025

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.

Jody Just
Residential Care Services

04/01/2025
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.

Administrator (or Representative)

04.09.2025
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

(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 medication services as prescribed, and within the allowable time frames, for 2 of 4 residents (Resident 3 and Resident 4) reviewed for implementation of medication services. This failure resulted in residents not receiving ordered medications on time and placed the residents at risk for harm and health complications.

Findings included...

Record review of a facility policy, titled, "Policy: 420 MEDICATION SERVICES", Revised 07/2008, regarding the facility's responsibility, showed that the facility will assure medications are taken in accordance with the health practitioner's instructions and that:

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.

Jody Just
Residential Care Services

04/01/2025
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.

Administrator (or Representative)

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

(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 medication services as prescribed, and within the allowable time frames, for 2 of 4 residents (Resident 3 and Resident 4) reviewed for implementation of medication services. This failure resulted in residents not receiving ordered medications on time and placed the residents at risk for harm and health complications.

Findings included...

Record review of a facility policy, titled, "Policy: 420 MEDICATION SERVICES", Revised 07/2009, regarding the facility's responsibility, showed that the facility will assure medications are taken in accordance with the health practitioner's instructions and that

medications must be provided for client within one hour prior or one hour after scheduled time per prescriber order.

<Resident 3>

Review of resident records showed that Resident 3 (R3) was admitted to the facility on [redacted] 2021 with diagnoses including [redacted].

Record review of R3's Service Agreement, dated 09/21/2024, showed that staff are to store, reorder, and assist resident with medications as prescribed by the prescriber.

On 02/18/2025, at 2:14 PM, during an interview, R3 stated that the facility was failing to deliver their Parkinson's medications on time.

Record review of R3's medication administration record (MAR), for January 2025 and February 2025, showed a medication used to treat the symptoms of Parkinson's was scheduled four times daily at 7:30 AM, 12:00 PM, 3:30 PM, and 7:30 PM.

Record review of R3's document, titled "Med Pass Details", dated 01/01/2025 through 02/20/2025, documented a medication used to treat the symptoms of Parkinson's disease was scheduled for 3:30 PM, and was given on the following dates and times:

- 5:35 PM on 01/10/2025.
- 5:24 PM on 01/11/2025.
- 6:06 PM on 01/12/2025.
- 4:39 PM on 01/13/2025.
- 5:21 PM on 01/14/2025.
- 5:44 PM on 01/18/2025.
- 5:10 PM on 01/23/2025.
- 4:42 PM on 01/24/2025.
- 4:46 PM on 01/25/2025.
- 5:29 PM on 01/29/2025.
- 6:24 PM on 01/31/2025.
- 5:14 PM on 02/03/2025.
- 4:55 PM on 02/13/2025.

Record review of R3's document, titled "Med Pass Details", dated 01/01/2025 through 02/20/2025, documented a medication used to treat the symptoms of Parkinson's disease was scheduled for 7:30 PM, and was given on the following dates and times:

- 8:37 PM on 01/02/2025.
- 9:11 PM on 01/07/2025.
- 9:32 PM on 01/11/2025.
- 9:08 PM on 01/14/2025.
- 8:47 PM on 01/17/2025.
- 8:50 PM on 01/24/2025.
- 9:01 PM on 01/26/2025.
- 9:00 PM on 01/28/2025.
- 9:28 PM on 01/29/2025.
- 9:04 PM on 02/01/2025.

<Resident 4>

Review of an undated face sheet showed Resident 4 (R4) was admitted to the facility on [redacted]/2024.

On 02/24/2025 at 1:32 PM, during an interview, R4 reported that the facility was failing to deliver their medications on time.

Record review of R4's Service Agreement, dated 01/17/2025, showed that staff are to store and provide medication assistance per prescribers orders.

Record review of R4's MAR, for January 2025 and February 2025, showed a medication to decrease blood pressure was scheduled for 8:00 AM and 5:00 PM.

Record review of R3's document, titled "Med Pass Details", dated 01/01/2025 through 02/20/2025, documented a medication to decrease blood pressure was scheduled for 8:00 AM, and was given on the following dates and times:

- 10:12 AM on 01/26/2025.
- 9:31 AM on 02/01/2025.
- 9:42 AM on 02/08/2025.
- 10:17 AM on 02/15/2025.

On 02/18/2025 at 12:50 PM, during an interview, Staff A, Health Service Director and Licensed Practical Nurse, reported that the facility was failing to provide medications on time and the records showed that several resident's medications were being delivered over an hour later than their scheduled time for the month of January and beginning of February.

Statement of Deficiencies	License #: 2529	Compliance Determination #:55089
Plan of Correction	Van Vista Assisted Living	Completion Date
Page 5 of 11	Licensee: Van Vista Plaza LLLP	03/21/2025

On 02/18/2025 at 01:20 PM, during an interview, Staff B, Health Services Coordinator, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:31 PM, during an interview, Staff C, medication technician, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:52 PM, during an interview, Staff D, medication technician, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:57 PM, during an interview, Staff E, Residential Care Coordinator, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/20/2025 at 02:50 PM, during an interview, Staff F, Executive Director, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

This is a recurring deficiency previously cited on 08/16/2023, 01/26/2023, 09/07/2022, and 09/22/2022 for subsections (1)(b), (2)(a), 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) ~~05 12 2025~~ or 05 05 2025

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

Administrator (or Representative): 04 09 2025 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.

On 02/18/2025 at 01:20 PM, during an interview, Staff B, Health Services Coordinator, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:31 PM, during an interview, Staff C, medication technician, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:52 PM, during an interview, Staff D, medication technician, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/18/2025 at 01:57 PM, during an interview, Staff E, Residential Care Coordinator, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

On 02/20/2025 at 02:50 PM, during an interview, Staff F, Executive Director, reported that the facility was failing to provide medications on time to several residents as medications were being delivered over an hour later than their scheduled time.

This is a recurring deficiency previously cited on 08/16/2023, 01/20/2023, 09/07/2022, and 03/22/2022 for subsections (1)(b), (2)(a), 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)_____ .

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

_____ _____

Administrator (or Representative) 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 interview and record review, the facility failed to obtain prescribed medications for 4 of 4 residents (Resident 1, Resident 2, Resident 3, and Resident 4) reviewed for availability of medications. This failure resulted in residents not receiving medications as ordered and placed the residents at risk for health complications due to not receiving their prescribed medications.

Findings included...

Record review of a facility policy, titled, "Policy: 420 MEDICATION SERVICES", revised 07/2009, regarding the facility's responsibility, showed that the facility will assure medications are taken in accordance with the health practitioner's instructions.

<Resident 1>

Review of resident records showed that Resident 1 (R1) was admitted to the facility on [redacted]/2020 with diagnoses including [redacted].

Record review of R1's Service Agreement, dated 01/25/2025, showed that staff are to store, reorder and assist with medication management as prescribed by the prescriber

On 02/18/2025 at 2:31 PM, during an interview, R1 stated that the facility would run out of some of their medications at times and that they wouldn't receive the medications when it happened.

Record review of R1's medication administration record (MAR), for January 2025, documented a medication to reduce stroke and blood clots was scheduled for 6:00 AM to 10:00 AM.

Record review of R1's MAR showed R1 was scheduled for 31 doses a medication to reduce stroke and blood clots and documented that two of the 31 doses were not given due to "Medication Unavailable" and "will call pharmacy", dates reviewed ranged from 01/01/2025 through 01/31/2025.

Record review of R1's MAR, for January 2025, documented that a medication to reduce allergies was scheduled for 6:00 AM to 10:00 AM.

Record review of R1's MAR, for January 2025, showed that a medication to reduce allergies was scheduled for 31 and documented that seven of the 31 doses were not

given due to "Pending Pharmacy Delivery", dates reviewed ranged from 01/01/2025 through 01/31/2025.

Record review of R1's MAR, for February 2025, documented that a medication to reduce allergies was scheduled for 6:00AM to 10:00AM.

Record review of R1's MAR, for February 2025, showed a medication to reduce allergies was scheduled for 20 doses and documented that five of the 20 doses were not given due to "Pending Pharmacy Delivery", dates reviewed ranged from 02/01/2025 through 02/20/2025.

<Resident 2>

Review of resident record showed that Resident 2 (R2) was admitted to the facility on [redacted]/2020 with diagnoses including [redacted].

Record review of R2's Service Agreement, dated 01/30/2025, showed "Staff to order, store and supply medications according to doctor orders."

On 02/18/2025, at 2:47 PM, during an interview, R2 stated that the facility would run out of some of their medications at times and that they wouldn't receive the medications when it happened.

Record review of R2's MAR, for January 2025, documented the following a supplement to increase calcium and vitamin D in the body was scheduled for 6:00 AM to 10:00 AM.

Record review of R2's MAR, for January 2025, showed that a supplement to increase calcium and vitamin D was scheduled for 31 doses and documented that two of the 31 doses were not given due to "Medication Unavailable", dates reviewed ranged from 01/01/2025 through 01/31/2025.

Record review of R2's MAR, for February 2025, documented a medication to help a person sleep was scheduled for 7:00 PM to 10:00 PM.

Record review of R2's MAR, for February 2025, showed a medication to help a person sleep was scheduled for 17 doses and documented that one of the 17 doses were not given due to "Medication Unavailable" and "Resident is completely out of this medication. Faxed pharmacy for more Trazodone", dates reviewed ranged from 01/01/2025 through 01/17/2025.

<Resident 3>

Review of resident records showed that Resident 3 (R3) was admitted to the facility on [redacted]/2021 with diagnoses including [redacted].

Record review of R3's Service Agreement, dated 09/21/2024, showed that staff are to store, reorder, and assist with medications as prescribed by the prescriber and that staff are to communicate with prescriber when a medication refill is needed.

On 02/18/2025, at 2:14 PM, during an interview, R3 stated that the facility would run out of some of their medications at times and that they wouldn't receive the medications when it happened.

Record review of R3's MAR, for January 2025, documented that a medication to help with digestion was scheduled for 8:00 AM.

Record review of R3's MAR, for January 2025, showed a medication to help with digestion was scheduled for 27 doses and documented that 13 of the 27 doses were not given due to "WAITING ON PHARMACY", "Medication Unavailable", "Pending Pharmacy Delivery", and "Other", dates reviewed ranged from 01/01/2025 through 01/27/2025.

Record review of R3's MAR, for February 2025, documented a supplement to increase vitamin B12 in the body was scheduled for 6:00 AM to 10:00 AM.

Record review of R3's MAR, for February 2025, showed that a supplement to increase vitamin B12 in the body was scheduled for 18 doses and documented that five of the 18 doses were not given due to "Pending Pharmacy Delivery", dates reviewed ranged from 02/01/2025 through 02/18/2025.

<Resident 4>

Review of resident records showed that Resident 4 (R4) was admitted to the facility on [redacted]2024 with diagnoses including [redacted].

Record review of R4's Service Agreement, dated 01/17/2025, showed that staff are to store and provide medication assistance per prescriber orders.

On 02/24/2025, at 1:32 PM, during an interview, R4 reported that the facility was failing to provide them some of their medications, some days, as the facility did not have the medications available.

Record review of R4's MAR, for January 2025, documented that a medication to decrease cholesterol levels in the blood was scheduled for 7:00 PM to 10:00 PM.

Record review of R4's MAR, for January 2025, showed that a medication to decrease cholesterol levels in the blood was scheduled for 31 doses and documented that 10 of the 27 doses were not given due to waiting on the medication from the pharmacy, dates reviewed ranged from 1/01/2025 through 1/31/2025.

Record review of R4's MAR, for January 2025, documented that a medication to aid in sleep was scheduled for 7:00 PM to 10:00 PM.

Record review of R4's MAR, for January 2025, showed that a medication to aid in sleep was scheduled for 31 doses and documented that 10 of the 27 doses were not given due to waiting on the medication from the pharmacy, dates reviewed ranged from 1/01/2025 through 1/31/2025.

Record review of R4's MAR, for January 2025, documented that a medication to decrease blood pressure was scheduled for 6:00AM to 10:00AM and 7:00PM to 10:00PM.

Record review of R4's MAR, for January 2025, showed that a medication to decrease blood pressure was scheduled for 62 doses and documented that 7 of the 62 doses were not given due to waiting on the medication from the pharmacy, dates reviewed ranged from 1/01/2025 through 1/31/2025.

Record review of R4's MAR, for February 2025, documented that a medication to decrease cholesterol levels in the blood was scheduled for 7:00PM to 10:00PM.

Record review of R4's MAR, for February 2025, showed that a medication to decrease cholesterol levels in the blood was scheduled for 19 doses and documented that four of the 27 doses were not given due to waiting on the medication from the pharmacy, dates reviewed ranged from 2/01/2025 through 1/19/2025.

Record review of R4's MAR, February 2025, documented that a medication to decrease blood pressure was scheduled for 6:00AM to 10:00AM and 7:00PM to 10:00PM.

Record review of R4's MAR, for February 2025, showed that a medication to decrease blood pressure was scheduled for 40 doses and documented that four of the 40 doses were not given due to waiting on the medication from the pharmacy, dates reviewed ranged from 2/01/2025 through 2/20/2025.

On 02/18/2025 at 12:50 PM, during an interview, Staff A, Health Service Director and Licensed Practical Nurse, reported that the facility was failing to provide some medications that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

On 02/18/2025 at 01:20 PM, during an interview, Staff B, Health Services Coordinator, reported that the facility was failing to provide some medications, that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

On 02/18/2025 at 01:31 PM, during an interview, Staff C, Medication Technician, reported that the facility was failing to provide some medications, that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

On 02/18/2025 at 01:52 PM, during an interview, Staff D, Medication Technician, reported that the facility was failing to provide some medications, that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

On 02/18/2025 at 01:57 PM, during an interview, Staff E, Residential Care Coordinator, reported that the facility was failing to provide some medications, that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

On 02/20/2025 at 02:50 PM, during an interview, Staff F, Executive Director, reported that the facility was failing to provide some medications, that were unavailable in the facility, to residents, partially due to issues with staff failing to order refills from the pharmacy on time.

This is a recurring deficiency previously cited on 11/10/2022.

Statement of Deficiencies	License # 2529	Compliance Determination # 550B9
Plan of Correction	Van Vista Assisted Living	Completion Date
Page 11 of 11	Licensee: Van Vista Plaza LLLP	03/21/2025

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, Van Vista Assisted Living is or will be in compliance with this law and / or regulation on (Date) ~~05-12-2025~~ 05-05-2025

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

Administrator (or Representative) — Date: 04-07-2025

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, Van Vista Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date