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

Sycamore Glen At Quail Hollow LLC
Sycamore Glen at Quail Hollow
506 N Ehorn Lane
Chewelah, WA 99109

RE: Sycamore Glen at Quail Hollow License # 2556

Dear Administrator:

This letter addresses Compliance Determination(s) 33967 (Completion Date 12/14/2023) and 31857 (Completion Date 11/08/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/14/2023 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-2950-6, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2-a, WAC 388-78A-2240

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

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

Sincerely,

S. Jm

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 31857
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 102803
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/30/2023 through 11/08/2023
Complainant Contact Date(s): 10/30/2023

Allegation(s):

1 - Lack of hot water for showers
2 - Staff restrained resident, resident had injury
3 - Medication omissions
4 - No assistance with dentures

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents' safety and well-being Any injuries Medication passes Hygiene Residents' use of dentures Water temperatures
Interviews:	Seven residents, including named resident Representative of named resident Medication aide/caregiver Caregiver Hospice staff Facility nurse Case Manager Behavior Support Specialist Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, and medication records Prescriber orders for named resident Facility's incident investigation documents Facility policy and procedures - Management of Aggression Staffing schedule - Aug - Oct 2023 Facility's water temperature logs Sample five staff's credentials

Investigation Summary:

1- As observed, water temperatures at sinks and showers in four apartments measured 64 - 92 degrees Fahrenheit (acceptable range was 105 - 120 degrees Fahrenheit). Five residents interviewed stated the water temperatures for showers were not hot enough. These residents stated they skipped or took showers outside their preferred times because of it. Failed facility practice was found, and cited under Washington Administrative Code (WAC) 388-78a-2950(6) Water supply.

2 - As observed, staff provided care to and interacted with residents in a calm, reassuring manner. Staff were also observed readily available to address residents' anxiety and did so effectively. Complainant did not furnish details about allegation. Information from interviews with residents did not support allegation. Staff interviewed showed the facility responded to aggression with interventions that were outlined in facility's policy and care plans. Per interview with facility staff and review of named resident's care plan, resident had history of inflicting self-injuries, and facility had interventions in place to address the behavior. Facility's behavioral interventions did not violate assisted-living rules. No failed facility practices were found.

3 - Interviews with named resident and facility nurse, and observation of the named resident's medication record showed facility omitted resident's medication over eight days. Per the named resident and nurse, the omission resulted in discomfort/frustration for the resident. Per interviews with facility staff, the error happened as the result of facility's recent change in how it communicated with the prescriber and pharmacy. Failed facility practice was found and cited under WAC 388-78a-2240 Non availability of medications. The facility also failed to ensure that medications were administered by the same staff who prepared the medications. Failed facility practice was found and cited under WAC 388-78a-2210(1)(a)(b),(2)(a) Medication services.

4 - As observed, named resident was wearing dentures and had no difficulty eating their meal. The resident stated there were no further issues since the issue was discussed with the facility. A sampled resident stated they needed dentures, and they were getting assistance to obtain them. This resident had no concerns about the care facility provided to them. No failed facility practices were found.

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: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 31857
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 103601
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 10/30/2023 through 11/08/2023
Complainant Contact Date(s): 10/27/2023, 10/31/2023

Allegation(s):

1 - Lack of hot water for showers
2 - No assistance with dentures
3 - Medication omissions
4 - Staff doesn't understand residents' needs
5 - Facility doesn't address grievances

Investigation Methods:

Sample:	Total residents: 19 Resident sample size: 8 Closed records sample size: 1
Observations:	Residents' safety and well-being Any injuries Medication passes Hygiene Residents' use of dentures Water temperatures Posted Resident Council minutes, advocacy contact information
Interviews:	Seven residents, including named resident Representative of named resident Medication aide/caregiver Caregiver Facility nurse Hospice staff Case Manager Behavior Support Specialist Administrator
Record Reviews:	Sample residents' Face Sheets, assessments, care plans, and medication records Prescriber orders for named resident Facility's incident investigation documents Staffing schedule - Aug - Oct 2023 Facility's water temperature logs

Sample five staff's credentials

Investigation Summary:

1 - As observed, water temperatures at sinks and showers in four apartments measured 64 - 92 degrees Fahrenheit (acceptable range was 105 - 120 degrees Fahrenheit). Five residents interviewed stated the water temperatures for showers were not hot enough. These residents stated they skipped or took showers outside their preferred times because of it. Failed facility practice was found, and cited under Washington Administrative Code (WAC) 388-78a-2950(6) Water supply.
2 - As observed, named resident was wearing dentures and had no difficulty eating their meal. The resident stated there were no further issues since the issue was discussed with the facility. A sampled resident stated they needed dentures, and they were getting assistance to obtain them. This resident had no concerns about the care facility provided to them. No failed facility practices were found.
3 - Interviews with named resident and facility nurse, and named resident's medication record showed facility omitted resident's medication over eight days. Per the named resident and nurse, the omission resulted in discomfort/frustration for the resident. Per interviews with staff, the error happened as the result of facility's recent change in how it communicated with the prescriber and pharmacy. Failed facility practice was found and cited under WAC 388-78a-2240 Non availability of medications. The facility also failed to ensure that medications were administered by the same staff who prepared the medications. Failed facility practice was found and cited under WAC 388-78a-2210(1)(a)(b),(2)(a) Medication services.
4 - As observed, staff responded promptly to residents' needs/concerns. Residents, including named resident, were observed without unmet needs. Per interviews with residents, including named resident, and staff; if residents and staff had difficulty understanding each other, other staff were available to assist. Reviews of sample staff's files showed they had the required credentials to provide care to vulnerable adults. No failed facility practices were found.
5 - As observed, staff were readily available to respond to residents' needs/concerns, and did so in a respectful, concerned manner. Residents interviewed, including named resident, and staff interviews did not support allegation. Facility had an active Resident Council, access to advocates, and information about the abuse/neglect hot-line. No failed facility practices were found.

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

Statement of Deficiencies	License #: 2556	Compliance Determination # 31857
Plan of Correction	Sycamore Glen at Quail Hollow	Completion Date
Page 1 of 5	Licensee: Sycamore Glen At Quail Hollow LLC	11/08/2023

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 10/30/2023, 10/30/2023 and 10/30/2023 of:

Sycamore Glen at Quail Hollow
506 N Ehorn Lane
Chewelah, WA 99109

This document references the following complaint number(s): 102803, 103601, 104327

The following sample was selected for review during the unannounced on-site visit: 8 of 19 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, 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.

Residential Care Services — Date: 11/16/2023

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 # 2558	Compliance Determination # 31857
Plan of Correction	Sycamore Glen at Quail Hollow	Completion Date
Page 2 of 5	Licensee: Sycamore Glen At Quail Hollow LLC	11/08/2023

Administrator (or Representative)

12/1/23
Date

WAC 388-78A-2950 Water supply. The assisted living facility must:

(6) Provide all sinks in resident rooms, toilet rooms and bathrooms, and bathing fixtures used by residents with hot water between 105 F and 120 F at all times; and

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure sink and shower water temperatures measured between 105 degrees and 120 degrees Fahrenheit in resident apartments for 5 of 7 sampled residents (Resident 1, 2, 3, 4, and 5). This failure resulted in the residents skipping showers or taking them outside of their preferred times and placed the residents at risk for poor hygiene and a decreased quality of life.

Findings included...

Observation on 10/30/2023 at 10:10 AM, showed the shower temperature in Resident 4's apartment measured 84 degrees Fahrenheit (F), and the sink temperature measured 78 degrees F . In an interview at that time, Resident 4 stated the water temperatures of their shower and sink were "real cold," so they skipped showers two times. The resident further stated that facility staff said they would fix the problem, but it had not been resolved.

Observation on 10/30/2023 at 10:30 AM, showed the shower temperature in Resident 5's apartment measured 84 degrees F, and the sink temperature measured 90 degrees F. In an interview at that time, Resident 5 stated the water temperature was "too cold" for taking showers.

Observation on 10/30/2023 at 12:15 PM, showed the shower temperature in Resident 2's apartment measured 80 degrees F, and the sink temperature measured 81 degrees F. In an interview at that time, Resident 2 stated the shower temperature was "very cold" that day, and the water temperatures in their apartment had been "too cold" for several days. Resident 2 further stated that several residents had complained about the water temperatures in their apartments being too cold for taking showers.

Observation on 10/30/2023 at 12:15 PM, showed the shower temperature in Resident 1's apartment measured 80 degrees F, and the sink temperature measured 81 degrees F. In an interview at that time, Resident 1 stated they skipped taking showers for two days because the water was too cold.

Observation on 10/30/2023 at 12:45 PM, showed the shower temperature in Resident 3's apartment measured 80 degrees F, and the sink temperature measured 90 degrees F. In an interview at that time, Resident 3 stated the water temperature in their apartment was often too cold for taking showers. The resident further stated they had tried to get up at 3:00 AM or 4:00 AM to see if the water temperature was warm enough, but those times were outside their preferred time for taking showers.

Statement of Deficiencies	License #: 2556	Compliance Determination # 31857
Plan of Correction	Sycamore Glen at Quail Hollow	Completion Date
Page 3 of 5	Licensee: Sycamore Glen At Quail Hollow LLC	11/08/2023

In an interview on 10/30/2023 at 3:05 PM, Staff A, Administrator, and Staff C, Behavioral Support Specialist, stated the facility had ongoing problems with the water temperatures in residents' apartments being too cold for showers. Staff A stated that staff tell residents to "wait a few hours" to see if the water is warm enough to take their showers. Staff A stated a broken valve caused the problem which Staff G, Owner, tried to fix and the problem with water temperatures persisted.

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, Sycamore Glen at Quail Hollow is or will be in compliance with this law and / or regulation on (Date) 12/4/23.

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

Brandon Pallett
Administrator (or Representative)

11/22/23
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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that medications were administered by the same staff who had prepared the medication for 2 of 7 sampled residents (Resident 6 and 7). These failures placed the residents at risk for medication errors.

Findings included...

<Resident 6>

Review of Resident 6's care plan, dated 10/20/2022, showed the facility used nurse-delegated staff to administer the resident's medications through a feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth).

On 10/30/2023 at 10:45 AM, Staff D, Medication Aide was observed preparing medications to be given to Resident 6 via feeding tube. The medications included liquid Tylenol (pain medication), lithium carbonate (medication used to treat a mood disorder) and prazosin (medication used to treat high blood pressure). Staff D was observed emptying the contents of lithium carbonate and prazosin capsules into the medication cup containing the liquid Tylenol.

In an interview on 10/30/2023 at 10:45 AM, Staff D stated they set up the medications for Residents 6 and Resident 7, then gave the medications to a different staff that could provide the medications through the feeding tubes for Residents 6 and Resident 7.

On 10/30/2023 at 11:05 AM, Staff D was observed handing the medication cup containing the medications to Staff E, a nurse-delegated caregiver, to give to Resident 6 via feeding tube.

<Resident 7>

Review of Resident 7's care plan, dated 04/26/2023, showed the facility used nurse-delegated staff to administer the resident's medications through a feeding tube.

On 10/30/2023 at 11:08 AM, Staff D was observed preparing medications to be given to Resident 7 via feeding tube. The medication included Tylenol. Staff D was observed crushing the Tylenol tablets and placing them in juice.

On 10/30/2023 at 11:10 AM, Staff D was observed handing the Tylenol to Staff F, a nurse-delegated caregiver, to give to Resident 7 via feeding tube.

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, Sycamore Glen at Quail Hollow is or will be in compliance with this law and / or regulation on (Date) 12/4/23

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

Administrator (or Representative) 11/23/24 Date

Statement of Deficiencies	License #: 2558	Compliance Determination # 31857
Plan of Correction	Sycamore Glen at Quail Hollow	Completion Date
Page 9 of 5	Licensee: Sycamore Glen At Quail Hollow LLC	11/08/2023

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 ensure prescribed medications were available for administration for 1 of 7 sampled residents (Resident 3). This failure resulted in Resident 3 experiencing frustration, discomfort, shakiness, and stiffness.

Findings included...

Review of Resident 3's prescriber's order, dated 10/13/2023, showed the prescriber changed the frequency of routinely scheduled carbidopa -levodopa (medication used to treat shaking and stiffness) from four times a day to be given to Resident 3 five times a day.

Review of the October 2023 medication administration record (MAR) for Resident 3 showed the facility did not start providing the fifth dose of routinely scheduled carbidopa levodopa until 10/21/2023 (nine days after ordered).

In an interview on 10/30/2023 at 12:40 PM, Resident 3 stated staff did not provide the fifth dose of routinely scheduled carbidopa-levodopa as ordered, over several days because the staff said not enough doses were available. The resident further stated the omissions resulted in "frustration" and "discomfort from shakiness and stiffness".

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, Sycamore Glen at Quail Hollow is or will be in compliance with this law and / or regulation on (Date) 12/4/23

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

Barbara Ballard
Administrator (or Representative)

11/22/23
Date

11/22/23

Sycamore Glen at Quail Hollow
Plan of correction:

Water Supply - WAC 388-78A-2950

- We had repairs completed to our hot water supply system on the following dates:
  - 10/27/23
    - Scott and Sons Heating performed inspection and evaluation on our hot water system.
  - 11/5/23
    - Heat exchanger was cleaned.
  - 11/10/23
    - Sebastian Heating performed inspection and diagnosis.
  - 11/15/23
    - Recirculating pumps and cartridges were replaced.
- We are continuing to monitor our hot water supply to identify if further repair is required.

Medication Services - WAC 388-78A-2210

- Staff re-training regarding medication administration was completed by our nursing staff on the following dates:
  - 11/11/23
  - 11/13/23
  - 11/18/23

Nonavailability of medications - WAC 388-78A-2240

- Staff re-training regarding medication delivery, prescription filling and refills was completed by our nursing staff on the following dates:
  - 11/11/23
  - 11/13/23
  - 11/18/23
- We updated our internal procedures for checking incoming faxes to include redundancies so no faxed medication changes are missed in the future.