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) 50656 (Completion Date 11/21/2024) and 45124 (Completion Date 10/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2024 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-2600-2-d, WAC 388-78A-2660-1, WAC 388-78A-2660-2, WAC 388-78A-2660-4, RCW 70.129.030.4

The Department staff who did the on-site verification:
Carla Rose, NCI Community Licensor

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: Sycamore Glen at Quail Hollow
License/Cert.#: 2556
Compliance Determination #: 45124
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 139408
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s): 07/30/2024, 08/15/2024

Allegation(s):

1 - Facility nurse forced people to work
2- Facility blocked resident(s) phone access to contacts
3 - Documentation "dummied"
4 - Medication cart "not right"
5 - Refrigerator temperatures are not monitored
6 - Employees smoke in inappropriate location
7 - Facility doesn't pay employees overtime
8 - Facility violates residents' rights e.g. moves resident into different room(s)
9 - Medications, i.e. Fentanyl provided to resident(s) without doctor's order
10 - Facility switched pharmacy
11- Medication ran out

Investigation Methods:

Sample:	Total residents: 20 Resident sample size: 20 Closed records sample size: 5
Observations:	Residents' safety and well-being Any injuries/signs of distress/unmet residents' needs Medication passes, cart, and system for accounting of medications Smoking safety Food storage e.g. refrigeration Staff's response to residents' needs/concerns
Interviews:	Ten residents, including alleged victims (AVs) Four resident representatives Three Medication Aides/Caregivers Facility caregiver Activity/transport staff Three facility nurses Two hospice staff Case Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans,

medication administration records (MARS), and Progress Notes
Disclosure of Services
Admission Agreement and facility rules
Kitchen temperature logs
Staffing schedules
Five sampled staff's credentials

Investigation Summary:

1 - Department investigator's attempts to contact complainant for clarification of this issue were unsuccessful. Information provided pertained to a setting that was outside the authority of the investigator therefore, no failed assisted-living practices were found related to the allegation.
2 - Staff was observed caring for and interacting with residents in a respectful manner. Residents interviewed, including alleged victim (AV), had no concerns related to phone access to visitors or advocates. Facility rules did not contain any language that was in violation of residents' rights. Investigation findings did not show failed facility practices/warrant citations.
3 - Department investigator's attempts to contact complainant for clarification of this issue were unsuccessful. Reviews of Progress Notes and MARS pertaining to sampled residents showed the facility documented residents' significant changes, and and information related to medication services, as required. Investigation findings did not show failed facility practices/warrant citations.
4 - Medication passes were observed done properly. Medications were observed stored securely in a double-locking cart; and staff was observed utilizing a system for checking medications against prescribers' orders before giving them, and reconciling narcotics. Investigation findings did not show failed facility practices/warrant citations.
5 - Residents interviewed had no concerns about the temperature of food. Thermometers were observed in refrigerators/freezers and facility had logs that showed temperatures were being monitored on a regular basis. Investigation findings did not show failed facility practices/warrant citations.
6 - Enforcement of laws related to smoking locations fall outside the authority of Residential Care and Services (RCS). No observations were made of unsafe smoking and facility assessed residents' ability to smoke safely. Investigation findings did not show failed facility practices/warrant citations.
7 - This allegation falls outside the authority of RCS investigations. Residents interviewed had no concerns about the care/assistance staff provided, such as staff's availability to respond to their needs. Investigation findings did not show failed facility practices/warrant citations.
8 - Residents, including AV, had no concerns about their apartments. Interview with the AV and staff showed the facility sometimes had residents move into different apartments to accommodate residents' comfort and preferences. Per these sources, the facility involved the affected residents in the process. Investigation findings did not show failed facility practices/warrant citations.
9 - Medications were observed being provided according to prescribers' orders. Residents interviewed had no concerns about their medications. Investigation findings did not show failed facility practices/warrant citations.
10 - Interviews with a resident representative and staff showed the facility changed the pharmacy it used without providing written notice to residents/representatives. Failed facility practice was found and documented in a Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660(1)(2)(4) Resident rights with reference to Revised Code of Washington (RCW) 70.129.030(4)(c) Notice of rights and services-Admission of individuals.
11 - Interviews with residents, representatives, and staff; and reviews of sampled

residents' MARS did not yield information that showed omissions of residents' medications. For one sampled resident whose pain medication ran out, it did not result in adverse outcome to the resident, and a refill of the medication was obtained quickly. Investigation findings did not show failed facility practices/warrant citations.

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 #: 45124
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 140880
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s): 08/01/2024, 08/15/2024

Allegation(s):

1 - Facility changed pharmacy without notifying residents/representative of residents
2 - Pain medication not available for a resident

Investigation Methods:

Sample:	Total residents: 20 Resident sample size: 20 Closed records sample size: 5
Observations:	Residents' safety and well-being Any injuries/signs of distress/unmet residents' needs Medication passes, cart, and system for accounting of medications Staff's response to residents' needs/concerns
Interviews:	Ten residents, including alleged victims (AVs) Four resident representatives Three Medication Aides/Caregivers Facility Caregiver Three facility nurses Case Manager Two hospice staff Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, medication administration records (MARS), and Progress Notes Disclosure of Services Admission Agreement and facility rules Staffing schedules Five sampled staff's credentials

Investigation Summary:

1 - Interviews with a resident representative and staff showed the facility changed the pharmacy it used without providing written notice to residents/representatives.

Failed facility practice was found and documented in a Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2660(1)(2)(4) Resident rights with reference to Revised Code of Washington (RCW) 70.129.030(4)(c) Notice of rights and services-Admission of individuals.
2 - Interviews with residents, representatives, and staff; and reviews of sampled residents' MARS did not yield information that showed omissions of residents' medications. For one sampled resident whose pain medication ran out, it did not result in adverse outcome to the resident, and a refill of the medication was obtained quickly. Investigation findings did not show failed facility practices/warrant citations.

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 #: 45124
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 141559
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s): 08/15/2024

Allegation(s):
Resident death in facility

Investigation Methods:

Sample:	Total residents: 20 Resident sample size: 20 Closed records sample size: 5
Observations:	Residents' safety and well-being Any injuries/signs of distress/unmet residents' needs Medication passes, cart, and system for accounting of medications Staff's response to residents' needs/concerns
Interviews:	Ten residents Four resident representatives, including for alleged victim (AV) Three Medication Aides/Caregivers Facility Caregiver Three facility nurses Police officer Home and Community Services Case Manager Administrator
Record Reviews:	Sampled residents' Face Sheets, assessments, care plans, medication administration records (MARS), and Progress Notes Hospital record for AV Physician Orders for Life-Sustaining Treatment (POLST) for AV Police documents pertaining to AV Disclosure of Services Admission Agreement and facility rules Facility's policies and procedures - tube feeding, unresponsive resident Staffing schedules - August and September 2024 Five sampled staff's qualifications and training

Investigation Summary:

Interviews with facility staff and police officer; Progress Notes; and police documents pertaining to AV showed there was approximately a half-hour delay of facility's call to 911 when staff found AV unresponsive. Failed facility practice was found and documented in a Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2600(2)(d) Policies and procedures.

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
Provider Type: Assisted Living Facility
License/Cert.#: 2556
Intake ID: 141309
Compliance Determination #: 45124
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s): 08/06/2024, 09/16/2024

Allegation(s):

1 - Staff gave resident(s) wrong medications
2 - Staff over-medicate resident(s)
3 - Staff didn't ensure resident(s) swallowed medication

Investigation Methods:

Sample:
Total residents: 20
Resident sample size: 20
Closed records sample size: 5

Observations:
Residents' safety and well-being
Any injuries/signs of distress/unmet residents' needs
Medication passes
Staff's response to residents' needs/concerns

Interviews:
Ten residents
Four resident representatives, including for AV
Three Medication Aides/Caregivers
Facility Caregiver
Three facility nurses
Two hospice staff
Home & Community Services Case Manager
Administrator

Record Reviews:
Sampled residents' Face Sheets, assessments, care plans, medication administration records (MARS), and Progress Notes
Disclosure of Services
Admission Agreement and facility rules
Facility's policies and procedures - unresponsive resident
Staffing schedules - August and September 2024
Five sampled staff's qualifications and training
Nurse-delegation documents

Investigation Summary:

1 - Medication passes were observed done properly and staff used a system for

checking medications against prescribers' orders before giving them. Review of prescriber's orders for alleged victim (AV) showed the named medication was ordered for the AV's nausea. No failed facility practice was found related to the use of medication for AV's nausea. However, investigation findings showed facility failed to provide written notice to residents/residents' representatives before pharmacy change. The deficiency was documented in a Statement of Deficiencies under Washington Administrative Code 388-78a-2660 (1)(2)(4) Resident rights with reference to Revised Code of Washington 70.129.030(4)(c) Notice of rights and services-Admission of individuals.
2 - Residents interviewed, including AV, did not have concerns related to medications. Named AV was observed with periods of drowsiness that could be due to resident's health issues and could not be specifically tied to their medication regimen. Reviews of sampled resident's MARS, including for AV, showed the staff provided medications as ordered by prescribers. Investigation findings did not show failed facility practices/warrant citations related to allegation.
3 - Observations of medication passes showed staff used proper medication assistance/administration procedures. Sampled staff had the required credentials and training to provide medications to residents. Investigation findings did not show failed facility practices/warrant citations related to allegation.

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 #: 45124
Investigator: Sylvia Shauvin
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 141615
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
Resident death in facility

Investigation Methods:

Sample:
Total residents: 20
Resident sample size: 20
Closed records sample size: 5

Observations:
Residents' safety and well-being
Any injuries/signs of distress/unmet residents' needs
Medication passes
Staff's response to residents' needs/concerns

Interviews:
Ten residents
Four resident representatives, including for alleged victim (AV)
Three Medication Aides/Caregivers
Facility Caregiver
Three facility nurses
Police officer
Home and Community Services Case Manager
Administrator

Record Reviews:
Sampled residents' Face Sheets, assessments, care plans, medication administration records (MARS), and Progress Notes
Hospital record for AV
Physician Orders for Life-Sustaining Treatment (POLST) for AV
Police documents pertaining to AV
Disclosure of Services
Admission Agreement and facility rules
Facility's policies and procedures - tube feeding, unresponsive resident
Staffing schedules - August and September 2024
Five sampled staff's credentials

Investigation Summary:

Interviews with facility staff and police officer; Progress Notes; and police documents pertaining to AV showed there was approximately a half-hour delay of facility's call to 911 when staff found AV unresponsive. Failed facility practice was found and documented in a Statement of Deficiencies under Washington Administrative Code (WAC) 388-78a-2600(2)(d) Policies and procedures.

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 #: 45124
Investigator: Sylvia Shauvin
Provider Type: Assisted Living Facility
Intake ID: 143308
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 08/02/2024 through 10/03/2024
Complainant Contact Date(s): 08/26/2024

Allegation(s):

1 - Resident was over-sedated
2 - Improper medical supervision
3 - Medical malpractice
4 - Facility's negligence resulted in death of resident

Investigation Methods:

Sample:
Total residents: 20
Resident sample size: 20
Closed records sample size: 5

Observations:
Residents' safety and well-being
Any signs of over-sedation
Medication passes
Any signs of unmet residents' needs
Staff presence and response to residents' needs/concerns

Interviews:
Ten residents
Four resident representatives, including representatives of alleged victim (AV)
Three Medication Aides/Caregivers
Facility Caregiver
Three facility nurses
Police officer
Home & Community Services Case Manager
Administrator
Facility owner

Record Reviews:
Sampled residents' Face Sheets, care plans, medication administration records (MARS), and Progress Notes
Hospital record of alleged victim (AV)
Physician Orders for Life Sustaining Treatment (POLST) for AV
Facility Incident Report regarding AV
Police summary pertinent to AV
Staffing schedules - August and September 2024
Five sampled staff's qualifications and training

Nurse delegation documents
Facility's policies and procedures - pertinent to tube feeding and unresponsive resident

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Investigation Summary:

1 - Residents interviewed did not have concerns related to medications. A medication aide was observed providing medication to the AV who was alert but due to their impaired cognition, was unable to provide details about their medications regimen. Another resident was observed with occasional drowsiness that was possibly related to their health issues, and could not be specifically tied to their medication regimen. Reviews of sampled resident's MARS, including for AV, showed the staff provided medications as ordered by prescribers. Investigation findings did not show failed facility practices/warrant citations related to allegation.
2 - This issue was outside of Residential Care Services' authority. Investigation findings did not support deficient facility practices/warrant citation related to this allegation.
3 - This issue was outside of Residential Care Services' authority. Investigation findings did not support deficient facility practices/warrant citation related to this allegation.
4 - Interviews with two staff that were with named resident (AV) when resident became unresponsive, and facility Incident Report showed the staff started cardiopulmonary resuscitation (CPR) on the AV and notified facility managers. Facility notified resident's representatives of the AV's death. Interviews with facility staff and police officer; and review of police documents pertaining to AV showed there was approximately a half-hour delay of facility's call to 911 when staff found AV unresponsive. Failed facility practice was found and documented in a Statement of Deficiencies (SOD) under Washington Administrative Code (WAC) 388-78a-2600(2)(d) Policies and procedures. Department investigator was unable to substantiate if action/inaction of facility contributed to AV's demise.

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 # 45124
Plan of Correction	Sycamore Glen at Quail Hollow	Completion Date
Page 1 of 6	Licensee: Sycamore Glen At Quail Hollow LLC	10/03/2024

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 08/02/2024, 08/02/2024 and 09/05/2024 of:

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

This document references the following complaint number(s): 139408, 140880, 141559, 141309, 141615, 143744, 143308

The following sample was selected for review during the unannounced on-site visit: 20 of 20 current residents and 5 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 — 10/072024 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

10/14/2024

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure staff properly implemented the facility's policy and procedures for 1 of 1 resident (Resident 17) who became unresponsive. This potentially resulted in the resident not receiving needed life-saving interventions.

Findings included...

Review of the facility's policy titled, "Resident Death," dated January 2011, showed in the event a resident was found unresponsive, staff should assess the resident to verify unresponsiveness, refer to the resident's code status posted on the resident's apartment door, start cardiopulmonary resuscitation (CPR), and call 911.

Review of Resident 17's Negotiated Care Plan (NCP, the facility's titled negotiated service agreement), dated 09/26/2023, showed that they had diagnoses including [redacted], [redacted], and [redacted]. The NCP also showed the resident received food and medications through a gastric (stomach) feeding tube.

Review of Resident 17's undated Patient Orders for Life-Sustaining Treatment (POLST) showed that if the resident had no pulse and was not breathing, staff should perform CPR, and full medical interventions should be provided.

Review of a Resident Note, dated 05/30/2024 at 3:30 PM, showed a neurologist stated scarring in Resident 17's brain placed the resident at risk of seizures.

Review of Resident Notes, dated 06/13/2024 at 5:30 PM and 06/18/2024 at 3:00 PM,

Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(d) When a resident stops breathing or a resident's heart appears to stop beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure staff properly implemented the facility's policy and procedures for 1 of 1 resident (Resident 17) who became unresponsive. This potentially resulted in the resident not receiving needed life-saving interventions.

Findings included…

Review of the facility's policy titled, "Resident Death," dated January 2011, showed in the event a resident was found unresponsive, staff should assess the resident to verify unresponsiveness, refer to the resident's code status posted on the resident's apartment door, start cardiopulmonary resuscitation (CPR), and call 911.

Review of Resident 17's Negotiated Care Plan (NCP, the facility's titled negotiated service agreement), dated 09/26/2023, showed that they had diagnoses including [redacted], [redacted] ([redacted]), [redacted] ([redacted]), and [redacted]. The NCP also showed the resident received food and medications through a gastric (stomach) feeding tube.

Review of Resident 17's undated Patient Orders for Life-Sustaining Treatment (POLST) showed that if the resident had no pulse and was not breathing, staff should perform CPR, and full medical interventions should be provided.

Review of a Resident Note, dated 05/30/2024 at 3:30 PM, showed a neurologist stated scarring in Resident 17's brain placed the resident at risk of seizures.

Review of Resident Notes, dated 06/13/2024 at 5:30 PM and 06/18/2024 at 3:00 PM,

showed that Resident 17 had seizures lasting 30 seconds to one minute.

Review of a Resident Note, dated 06/28/2024 at 4 PM, showed speech therapy (treatment for people with swallowing disorders) for Resident 17 was stopped. The note showed that the speech therapist recommended the facility not give Resident 17 oral foods and fluids due to aspiration (a condition in which food/fluids taken by mouth goes into the lungs instead of stomach, placing the resident at risk of pneumonia, a lung infection).

In an interview on 08/08/2024 at 11:45 AM, Staff A, Administrator, informed the department investigator that Resident 17 passed away in the facility on [redacted]/2024 at 8:45 PM.

In an interview on 08/08/2024 at 3:55 PM, Collateral Contact 2 (CC2), Law Enforcement, stated their records showed facility staff contacted Staff A on [redacted]/2024 at 8:46 PM, Staff A contacted Staff C, Facility Nurse, at 8:48 PM, and Staff C called 911 at 9:19 PM. CC2 stated these times showed there was a delay of "about one-half hour" before a 911 call was placed.

In an interview on 08/09/2024 at 12:57 PM, Staff G, Caregiver, stated on the evening of [redacted]/2024 they and Staff F, Caregiver, had laid Resident 17 into bed, and around 8:00 PM, they were tidying up Resident 17's apartment, including moving the resident's wheelchair into the hallway, and preparing to do laundry. Staff G described going over to the resident's bedside, and when they touched the resident's hand and feet, the resident's skin felt cold. Staff G stated when they checked Resident 17's oximeter level (a procedure to check the level of oxygen in the blood), the screen of the oximeter was "black," and when they checked Resident 17's temperature, it was "90 degrees". Staff G stated they called Staff F into Resident 17's apartment, then called Staff B, Facility Nurse, Staff D, Executive Director, and Staff A who instructed them to call 911. Staff G estimated about 15-20 minutes after making calls, Staff C, nurse, and Staff E, Behavior Specialist Assistant, arrived at the facility then Staff C called 911.

In the interview on 08/09/2024 at 12:57 PM, Staff G stated Staff F started CPR after they checked Resident 17's oximetry and temperature and made calls to facility managers. Staff G was uncertain about the time CPR was initiated and estimated they and Staff F performed CPR for about five minutes before 911 showed up.

In an interview on 08/12/2024 at 8:17 AM, Staff B, Registered Nurse, stated they went to the facility at around 9:30 PM on [redacted]/2024, after Staff C pronounced Resident 17 deceased, to provide information to the police and mortuary.

In an interview on 08/12/2024 at 1:15 PM, Staff F stated on the evening of [redacted]/2024 when they and Staff G checked on Resident 17, "we saw [resident] wasn't moving [their] hands," and "something was wrong," although Staff F was unsure of the time, they noticed this. Staff F stated they initiated CPR after Staff G checked Resident 17's

showed that Resident 17 had seizures lasting 30 seconds to one minute.

Review of a Resident Note, dated 06/28/2024 at 4 PM, showed speech therapy (treatment for people with swallowing disorders) for Resident 17 was stopped. The note showed that the speech therapist recommended the facility not give Resident 17 oral foods and fluids due to aspiration (a condition in which food/fluids taken by mouth goes into the lungs instead of stomach, placing the resident at risk of pneumonia, a lung infection).

In an interview on 08/08/2024 at 11:45 AM, Staff A, Administrator, informed the department investigator that Resident 17 passed away in the facility on [redacted]/2024 at 8:45 PM.

In an interview on 08/08/2024 at 3:55 PM, Collateral Contact 2 (CC2), Law Enforcement, stated their records showed facility staff contacted Staff A on [redacted]/2024 at 8:46 PM, Staff A contacted Staff C, Facility Nurse, at 8:48 PM, and Staff C called 911 at 9:19 PM. CC2 stated these times showed there was a delay of “about one-half hour” before a 911 call was placed.

In an interview on 08/09/2024 at 12:57 PM, Staff G, Caregiver, stated on the evening of [redacted]/2024 they and Staff F, Caregiver, had laid Resident 17 into bed, and around 8:00 PM, they were tidying up Resident 17’s apartment, including moving the resident’s wheelchair into the hallway, and preparing to do laundry. Staff G described going over to the resident’s bedside, and when they touched the resident’s hand and feet, the resident’s skin felt cold. Staff G stated when they checked Resident 17’s oximeter level (a procedure to check the level of oxygen in the blood), the screen of the oximeter was “black,” and when they checked Resident 17’s temperature, it was “90 degrees”. Staff G stated they called Staff F into Resident 17’s apartment, then called Staff B, Facility Nurse, Staff D, Executive Director, and Staff A who instructed them to call 911. Staff G estimated about 15-20 minutes after making calls, Staff C, nurse, and Staff E, Behavior Specialist Assistant, arrived at the facility then Staff C called 911.

In the interview on 08/09/2024 at 12:57 PM, Staff G stated Staff F started CPR after they checked Resident 17’s oximetry and temperature and made calls to facility managers. Staff G was uncertain about the time CPR was initiated and estimated they and Staff F performed CPR for about five minutes before 911 showed up.

In an interview on 08/12/2024 at 8:17 AM, Staff B, Registered Nurse, stated they went to the facility at around 9:30 PM on [redacted]/2024, after Staff C pronounced Resident 17 deceased, to provide information to the police and mortuary.

In an interview on 08/12/2024 at 1:15 PM, Staff F stated on the evening of [redacted]/2024 when they and Staff G checked on Resident 17, “we saw [resident] wasn’t moving [their] hands,” and “something was wrong,” although Staff F was unsure of the time, they noticed this. Staff F stated they initiated CPR after Staff G checked Resident 17’s

oximetry and temperature and after calling facility managers.

In an interview on 08/12/2024 at 2:25 PM, Staff C stated Staff F and Staff G informed them that they (Staff F and G) initiated CPR at 8:30 PM and that when Staff C arrived at the facility, Staff F and G had stopped CPR because there was no response from Resident 17. Staff C stated 911 arrived after Staff C arrived at the facility at about 9:10 PM.

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) 11/11/2024.

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

Julie L. Chambers — Administrator (or Representative)

10/11/2024 — Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129 RCW;

(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Based on observations and interviews, the facility failed to provide 30 days written notice to residents/residents' representatives before making a change of pharmacy for 20 of 20 residents/resident representatives (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20). This failure violated the residents' right to use their preferred pharmacy.

Findings included...

In an interview on 08/01/2024 at 10:45 AM, Collateral Contact 1 (CC1), representative of Residents 4, 7, 8,15, 16, and 20, stated they were upset about the facility changing the pharmacy it used without notification to resident representatives. CC1 stated the facility arranged to use an out-of-town pharmacy.

Review of an email, dated 07/31/2024 at 11:48 AM from CC1 to Staff A, Administrator, Staff E, Behavior Specialist Assistant, and the medication prescriber, showed that CC1 stated they were enrolling Residents 4, 7, 8, 15, 16, and 20 with CC1's preferred pharmacy that was nearby the facility, "effective immediately."

Review of an email dated, 08/01/2024 at 4:10 PM from CC1 to the medication prescriber and CC1's preferred pharmacy, showed that CC1 stated the facility changed the pharmacy it used for CC1's six residents "without my authorization/consent," on 05/31/2024.

In an interview on 08/02/2024 at 11:35 AM Staff H, Medication Aide, stated the facility changed the pharmacy it used, but did not know the details, adding it was a management decision. Staff H estimated the facility had been using a different pharmacy for two months.

In an interview on 08/02/2024 at 1:45 PM Staff A, stated the facility changed the pharmacy it used in May 2024. Staff A stated Staff B, Registered Nurse, initiated the pharmacy change for all 20 of its current residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20), adding none of the facility managers were aware of the requirement to notify residents/residents' representatives when the facility changed the pharmacy it used.

In an interview on 08/08/2024 at 12:45 PM, Staff C, Registered Nurse, stated they did not know why the facility changed the pharmacy it used and believed the change had to do with problems related to the timing of medication delivery from the former pharmacy.

In an interview on 08/08/2024 at 1:25 PM, Staff B stated the facility did not give residents/residents' representatives 30 day written notices in advance of the facility's plan to change the pharmacy it used.

This requirement was not met as evidenced by:

Based on observations and interviews, the facility failed to provide 30 days written notice to residents/residents' representatives before making a change of pharmacy for 20 of 20 residents/resident representatives (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20). This failure violated the residents' right to use their preferred pharmacy.

Findings included…

In an interview on 08/01/2024 at 10:45 AM, Collateral Contact 1 (CC1), representative of Residents 4, 7, 8,15, 16, and 20, stated they were upset about the facility changing the pharmacy it used without notification to resident representatives. CC1 stated the facility arranged to use an out-of-town pharmacy.

Review of an email, dated 07/31/2024 at 11:48 AM from CC1 to Staff A, Administrator, Staff E, Behavior Specialist Assistant, and the medication prescriber, showed that CC1 stated they were enrolling Residents 4, 7, 8, 15, 16, and 20 with CC1's preferred pharmacy that was nearby the facility, "effective immediately."

Review of an email dated, 08/01/2024 at 4:10 PM from CC1 to the medication prescriber and CC1's preferred pharmacy, showed that CC1 stated the facility changed the pharmacy it used for CC1's six residents "without my authorization/consent," on 05/31/2024.

In an interview on 08/02/2024 at 11:35 AM Staff H, Medication Aide, stated the facility changed the pharmacy it used, but did not know the details, adding it was a management decision. Staff H estimated the facility had been using a different pharmacy for two months.

In an interview on 08/02/2024 at 1:45 PM Staff A, stated the facility changed the pharmacy it used in May 2024. Staff A stated Staff B, Registered Nurse, initiated the pharmacy change for all 20 of its current residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20), adding none of the facility managers were aware of the requirement to notify residents/residents' representatives when the facility changed the pharmacy it used.

In an interview on 08/08/2024 at 12:45 PM, Staff C, Registered Nurse, stated they did not know why the facility changed the pharmacy it used and believed the change had to do with problems related to the timing of medication delivery from the former pharmacy.

In an interview on 08/08/2024 at 1:25 PM, Staff B stated the facility did not give residents/residents' representatives 30 day written notices in advance of the facility's plan to change the pharmacy it used.

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) 11/11/2024.

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

Administrator (or Representative) — Date 10/11/2024

RECEIVED
OCT 16 2024
DSHS ALTSA RCS
SPOKANE VALLEY WA