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

SPOKANE UNITED METHODIST HOMES
Rockwood at Whitworth
10331 N Mayberry Drive
Spokane, WA 99218

RE: Rockwood at Whitworth # 2577

Dear Administrator:

This document references Compliance Determination 52535 (01/06/2025), which included complaint number(s) 160469.

The Department completed a complaint investigation of your Assisted Living Facility on 01/06/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Amy Wright, NCI Complain Investigator

Consultation:

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(1) The assisted living facility must secure medications for residents who are not capable of safely storing their own medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

Resident had Nystatin powder and was left at bedside in resident's room who requires

assistance with medication. No outcome. Once facility was notified, they corrected the matter and provided in-service.

You Must:
• Begin the process of correcting the deficiency or deficiencies immediately; and
• Complete correction as soon as possible.

You Are Not:
• Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
• Inspect the facility to determine if you have corrected all deficiencies.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

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

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

If You Have Any Questions:
• Please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Rockwood at Whitworth
Provider Type: Assisted Living Facility

License/Cert.#: 2577
Intake ID: 160469
Compliance Determination #: 52535
Region/Unit #: RCS Region 1 / Unit B
Investigator: Amy Wright
Investigation Date(s): 01/03/2025 through 01/06/2025
Complainant Contact Date(s): 01/03/2025, 01/07/2025

Allegation(s):

1. Resident not receiving increased level of care for perineal care and bathing as care planned.
2. Nurses not available for wound care.
3. Medication left in resident apartment.
4. Topical medication not being applied as ordered.

Investigation Methods:

Sample:	Total residents: 75 Resident sample size: 3 Closed records sample size: 0
Observations:	Alleged Victim Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Health Care Services Director Alleged Victim Resident Representatives Resident Alleged Victim's Representative
Record Reviews:	*Disclosure of Services *Characteristic roster *Staff roster *Resident face sheets *Resident care plans *Progress notes *Medication administration records *Treatment administration records *Shower documentation *Medication Management Policy

Investigation Summary:

1. The facility coordinated with a home health agency and the Alleged Victim's family. The Alleged Victim's plan of care was updated to reflect their increased need for assistance. Record review showed that staff provided the Alleged Victim assistance with showers according to their plan of care. The Alleged Victim was interviewed, and they denied having any unmet needs. Staff were observed available to assist with resident care when needed. No failed facility practice.
2. The Alleged Victim was interviewed, and they reported that the facility nurses were providing them with routine wound care. Review of a treatment administration record verified that the wound care was occurring as ordered. Facility nurses were observed available to provide wound care when needed. No failed facility practice.
3. A prescribed medication was observed in the Alleged Victim's bathroom without the presence of staff. Upon interview, the Alleged Victim reported that they kept the medication in their apartment. Failed facility practice identified and cited under WAC 388-78A-2260 Storing, securing, and accounting for medications (1)(2)(d).
4. Review of the Alleged Victim's medication administration record showed that the topical medication was applied routinely as ordered. The Alleged Victim was interviewed. They stated that staff had been applying the topical medication, and that the medication had been effective. Staff were observed available to assist with medications when needed. No failed facility practice.

Conclusion / Action:

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