STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Puyallup Memory Care LLC
Deer Ridge Memory Care Community
3901 5th St SE
Puyallup, WA 98374

RE: Deer Ridge Memory Care Community License # 2578

Dear Administrator:

This letter addresses Compliance Determination(s) 29660 (Completion Date 11/01/2023) and 20461 (Completion Date 05/19/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/01/2023 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-2371-2, WAC 388-78A-2371-1, WAC 388-78A-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2600, WAC 388-78A-2600-2, WAC 388-78A-2600-1-a, WAC 388-78A-2600-1-b, WAC 388-78A-2600-2-a

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Deer Ridge Memory Care Community
License/Cert.#: 2578
Compliance Determination #: 20461
Investigator: Carol Gijima
Investigation Date(s): 02/28/2023 through 05/19/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 67128
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):

1. Facility did not investigate resident fall
2. Facility did not notify family of resident fall

Investigation Methods:

Sample:	Total residents: Resident sample size: 1 Closed records sample size: 1
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Resident representative Staff
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including discharged records the records of the named resident Medication administration records (MAR) Staff records Staff progress notes Medical records (lab reports, H & P summary)' Incident log / reports

Investigation Summary:

1. Per record review, interviews resident's representative and staff, the facility failed to investigate resident falls or take appropriate action to prevent recurrence. Failed facility practice identified. See Statement of Deficiency dated 05/19/2023.
2. Per record review, interviews of resident's representative and staff, the facility failed to notify the resident's representative and physician when the resident sustained a fall with serious injury. Failed practice identified. No additional citations written as facility is currently out of compliance. See Statement of Deficiency dated 05/23/2023.

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

PO Box 99250, Lakewood, WA 98496

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 02/28/2023 and 05/11/2023 of:

Deer Ridge Memory Care Community
3901 5th St SE
Puyallup, WA 98374

This document references the following complaint number(s): 67128, 81506

The following sample was selected for review during the unannounced on-site visit: 1 of 0 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)
Manfay Chan, Allied Health Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services

08/24/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to investigate circumstances surrounding resident's falls with one resulting in a left clavicle fracture (a break in the collarbone) for 1 of 2 sampled resident (Resident 1). This failure contributed to the resident having recurring falls, hospitalization, pain, and a decrease in quality of life.

Findings Included…

Record review on 02/28/2023 showed that Resident 1 (R1) was admitted to ALF on [redacted]/2021 with diagnoses to include [redacted] A care plan dated 09/21/2021 showed no fall problems.

Review of incident reports provided by the facility showed that R1 sustained falls on the following dates:
Fall on 07/22/2022 resulting in a head injury.
Fall on 08/12/2022 resulting in blunt head trauma.
There were no investigations conducted for the falls.

Record review of hospital records showed that R1 sustained a head injury after a fall on 07/22/2022, and records dated 07/30/2022 showed that R1 sustained a displaced clavicle fracture after sustaining a fall on 07/27/2022.

Review of progress notes did not have documentation of the 07/27/2022 fall. There were no incident reports for the 07/27/2022 fall and or investigation of this fall.

During an interview on 02/27/2023 at 1:52pm, Resident 1's Representative (RR1) stated that R1 had unexplained bruises to the face, neck, back of neck and thigh, and complained of shoulder pain during a family visit on 07/30/2022. RR1 stated that when R1's daughter asked about it, she was told R1 was given some pain medications. RR1 stated the facility

did not know how R1 sustained the bruises or the fracture after family took her to the hospital on 07/30/2022. RR1 stated that the Administrator informed them that there was a fall on 07/27/2022 that had not been documented.

During an interview on 02/28/2023 at 10:25am, Staff B, Medication Technician (Med Tech) stated that R1 was fun, walked around, and was always with her group of friends. Staff B stated that R1 started having recurring falls. When asked what interventions were put in place to prevent the falls, Staff B stated R1 was not to ambulate on her own and they had frequent checks. When asked if that was care planned, Staff B stated she didn't remember.

During an interview on 02/28/2023 at 11:26am, Staff A, Administrator was asked what the findings of the investigation were, and she stated she didn't know. Staff A stated she didn't know what happened with the falls, and stated she didn't know what interventions were put in place. Staff A did not provide an answer when asked how they ruled out abuse or neglect of R1. Staff A stated R1 had a fall which was not documented and there wasn't an incident report.

This is a recurring deficiency previously cited on 10/05/2022, 09/09/2022 and 06/23/2022.

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, Deer Ridge Memory Care Community 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-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to assess, evaluate, or monitor a resident's change in physical function after sustaining falls for 1 of 2 sampled residents (Resident 1). This failure contributed to Resident 1 (R1) to continue having falls, hospitalization, and decline in health.

Findings Included…

Record review on 02/28/2023 showed that Resident 1 (R1) was admitted to the ALF on [redacted]/2021 with diagnoses to include [redacted]. A care plan dated 09/21/2021 showed no fall problems. There was no temporary service plan provided to show fall interventions. Further review of the facility incident reports showed that R1 sustained the following falls:
Fall on 07/22/2022 resulting in a head injury.
Fall on 08/12/2022 resulting in a blunt head trauma.
There was no documentation that resident was assessed or monitored for a change in condition.
There was no documentation of interventions being put in place to prevent any of the falls.

Record review of hospital records showed that R1 sustained a head injury after a fall on 07/22/2022, and records dated 07/30/2022 showed that R1 sustained a displaced clavicle fracture after sustaining a fall on 07/27/2022.

Review of progress notes did not have documentation of the 07/27/2022 fall . There were no incident reports for the 07/27/2022 fall and or investigation of this fall.

During an interview on 02/27/2023 at 1:52pm, Resident 1's Representative (RR1) stated that R1 was independent with mobility and did not have any problems. RR1 stated that R1 started having falls and the facility didn't reassess her to see what the cause of these falls were, and that they had "no action, no fall plan." RR1 stated that the Administrator stated that R1 moved fast and was very active.

During an interview on 02/28/2023 at 10:25am, Staff B, Medication Technician (Med Tech) stated that R1 was fun, walked around, and was always in the company of a group of friends. Staff B stated that R1 started having falls and was unsure why.

During an interview on 02/28/2023 at 11:26am, Staff A, Administrator was asked if R1 was assessed after the first fall (07/22/2022) to determine the cause of the fall. Staff A stated R1 had a walker with her and "really walks fast". Staff A stated R1 was encouraged to walk slow. When asked about the 07/27/2022 fall, Staff A stated she didn't know if a nurse assessed her after the fall. Staff A was asked what interventions were put in place to prevent R1 from falling, she stated she didn't know. Staff A was asked if the falls would not

be considered a significant change in condition since resident had no prior history of falls and would need to be reassessed. Staff A stated she didn't know if R1 was reassessed.

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, Deer Ridge Memory Care Community 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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living Facility (ALF) failed to train their employees to implement their policies on how to investigate incidents of abuse and neglect when staff did not respond to a resident fall for 1 of 2 sample residents (Resident 1). This failure contributed to Resident 1 sustaining a clavicle fracture (a break in the collarbone), and pain for days.

Findings Included…

Review on 05/11/2023 of the facility's "Incident Reporting for Communities" policy dated January 2022 showed that "All accidents/incidents will be responded to and investigated promptly…must be completed on the date of occurrence…should include a detailed description of the incident, possible factors contributing to the incident, staff interventions, or actions taken…."

Record review of staff training documents on 05/11/2023, showed that Staff D and Staff E, Licensed Nurses, did not have training on how to manage resident incidents.

Record review on 02/28/2023 showed that Resident 1 (R1) admitted to ALF on [redacted]/2021 with diagnoses to include [redacted] A care plan dated 09/21/2021 showed no fall problems. Facility records showed that R1 had falls on the following dates: 07/22/2022and 08/12/2022.

Record review of hospital records showed that R1 sustained a head injury after a fall on 07/22/2022, and records dated 07/30/2022 showed that R1 sustained a displaced clavicle fracture after sustaining a fall on 07/27/2022.

Review of progress notes did not have documentation of the 07/27/2022 fall . There were no incident reports for the 07/27/2022 fall and or investigation of this fall.

During an interview on 05/11/2023 at 10:15am, Staff C, Licensed Nurse was asked if she had been trained on how to manage incidents. Staff C stated that she was a seasoned nurse and knew what to do.

During an interview on 05/11/2023 at 10:35am, Staff A, Administrator was asked if staff were trained on “Incident Reporting for Communities” policy dated January 2022. Staff A stated they were trained during orientation and signed off the checklist. When asked if agency staff were also trained before working with residents, Staff A stated she tried her best.

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, Deer Ridge Memory Care Community 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