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) 29661 (Completion Date 10/02/2023) and 23322 (Completion Date 05/11/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/02/2023 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-2210, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

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
Provider Type: Assisted Living Facility
License/Cert.#: 2578
Intake ID: 75107
Compliance Determination #: 23322
Region/Unit #: RCS Region 3 / Unit D
Investigator: Marilyn Klotz
Investigation Date(s): 05/02/2023 through 05/11/2023
Complainant Contact Date(s):

Allegation(s):

Family member alleged loved one had been isolated from the rest of the community, and also alleged loved one did not receive eye drops as prescribed by the provider.

Investigation Methods:

Sample:
Total residents: 50
Resident sample size: 7
Closed records sample size: 0

Observations:
An observation of Resident 1 on 05/02/2023 at 9:35 a.m. revealed the resident eating breakfast in the dining area amongst other residents and staff. The resident was pleasant, and alert to self only. The resident was not interviewable.

Interviews:
A telephone interview with Family Member A on 05/03/2023 at 8:42 a.m. revealed they were concerned that Resident 1 had not received the prescribed eye drop medication Latanoprost for glaucoma. The family member went onto state they had noticed staff giving Resident 1 evening eye drops; however, they were not in the same-colored vial as the previously administered Latanoprost. They revealed they had confirmed with their family member's pharmacy and had been informed the Latanoprost eye drops had only been sent to the facility in June 2022, and again in March 2023.
Telephone interview with the Staff B contracted pharmacist on 5/2/2023 at 2:50 p.m. revealed the pharmacy had sent Resident 1's Latanoprost eye drops to the facility on 06/19/2022, and not again until 03/08/2023. The pharmacist stated each vial of the eye drops had enough medication for 50 doses, or 25 days. They went onto state Latanoprost was most often given to patients with glaucoma.
Interview with the Staff C Director of Resident Services on 05/03/2023 at 8:45 a.m. revealed they would have drawn the same conclusions as the family member regarding Resident 1's eye drops not being properly administrated by the staff. They stated staff signage of their initials on the medication sheet confirmed the medication had been given, and staff

initials with a circle around the initials indicated the medication had been held. The Director of Resident Services revealed staff should have ordered additional eye drops from the pharmacy. They went onto state he/she had passed medications occasionally, however, he/she had not been notified by the staff or the family that the medication had been marked as given, when in fact it appeared the medication had not been available on the medication cart. They stated staff should administer medications to the residents per the physician's order.
Telephone interview with Staff D Facility Director on 05/03/2023 at 9:11 a.m. revealed they had not been made aware Resident 1's medication Latanoprost had been signed off by staff as administered during a time frame where the medication was not in the building. The Director revealed staff have been instructed to call or fax the pharmacy when a medication needed to be refilled.
Interview with Staff E Certified Nursing Assistant/Medication Technician on 05/03/2023 at 10:19 a.m. revealed whenever a medication was not available to administer to a resident, the staff should circle their initials, and write a brief explanation on why the medication was held on the back of the resident's medication record. The staff should then complete a medication request and fax it to the pharmacy and make the nurse aware that the medication had been ordered. They stated staff had to go through the steps when a medication needed to be refilled, and staff cannot just mark off a medication as given if the medication had not been available to give. They reveled when staff initials were not circled on the medication sheet, the medication was given to the resident as prescribed by the provider.

Record Reviews:

Admissions records stated Resident 1 was admitted to the facility on [redacted]/2022 with diagnoses including [redacted], and [redacted].
Review of the policy and procedure titled, "Medication Pharmacy Procedures" no date, stated, "Administering- All drugs will be dispensed in a manner compliant with the prescribed procedure. The nurse will be responsible for preparing, administering, and recording medications. Charting of Medications- The nurse administering the medication must also assume the responsibility for charting the drug. Charting medications must be kept current and completed directly with the administration of the drug."
Review of the "90 Day Order Form" dated, 05/03/2022, revealed the initial order for Latanoprost 1 drop to each eye daily.
However, review of the "Routine Orders" revealed staff had documented the eye drops had been administered to Resident 1 during the months of July through December 2022 and January through February as well as March 1st through March 7th, 2023.

Investigation Summary:

Regulatory Requirement- WAC 388-78A-2210- Medication Services

Based on interview, record review, and policy review, the facility failed to receive their medications as prescribed for 1 of 5 residents (Resident 1). This failure placed the resident at risk by not receiving medications prescribed for Glaucoma.
Findings included…
Admissions records stated Resident 1 was admitted to the facility on [redacted]/2022 with diagnoses including [redacted], and [redacted].
Review of the policy and procedure titled, “Medication Pharmacy Procedures” no date, stated, “Administering- All drugs will be dispensed in a manner compliant with the prescribed procedure. The nurse will be responsible for preparing, administering, and recording medications. Charting of Medications- The nurse administering the medication must also assume the responsibility for charting the drug. Charting medications must be kept current and completed directly with the administration of the drug.”
An observation of Resident 1 on 05/02/2023 at 9:35 a.m. revealed the resident eating breakfast in the dining area amongst other residents and staff. The resident was pleasant, and alert to self only. The resident was not interviewable.
A telephone interview with Family Member A on 05/03/2023 at 8:42 a.m. revealed they were concerned that Resident 1 had not received the prescribed eye drop medication Latanoprost for glaucoma. The family member went onto state they had noticed staff giving Resident 1 evening eye drops; however, they were not in the same-colored vial as the previously administered Latanoprost. They revealed they had confirmed with their family member’s pharmacy and had been informed the Latanoprost eye drops had only been sent to the facility in June 2022, and again in March 2023.
Review of the “90 Day Order Form” dated, 05/03/2022, revealed the initial order for Latanoprost 1 drop to each eye daily.
Telephone interview with the Staff B contracted pharmacist on 5/2/2023 at 2:50 p.m. revealed the pharmacy had sent Resident 1’s Latanoprost eye drops to the facility on 06/19/2022, and not again until 03/08/2023. The pharmacist stated each vial of the eye drops had enough medication for 50 doses, or 25 days. They went onto state Latanoprost was most often given to patients with glaucoma.
However, review of the “Routine Orders” revealed staff had documented the eye drops had been administered to Resident 1 during the months of July through December 2022 and January through February as well as March 1st through March 7th, 2023.
Interview with the Staff C Director of Resident Services on 05/03/2023 at 8:45 a.m. revealed they would have drawn the same conclusions as the family member regarding Resident 1’s eye drops not being properly administrated by the staff. They stated staff signage of their initials on the medication sheet confirmed the medication had been given, and staff initials with a circle around the initials indicated the medication had been held. The Director of Resident Services revealed staff should have ordered additional eye drops from the pharmacy. They went onto state he/she had passed medications occasionally, however, he/she had not been notified by the staff or the family that the medication had been marked as given, when in fact it appeared the medication had not been available on the medication cart. They stated staff should administer medications to the residents per the physician’s order.
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Interview with Staff E Certified Nursing Assistant/Medication Technician on 05/03/2023 at 10:19 a.m. revealed whenever a medication was not available to administer to a resident, the staff should circle their initials, and write a brief explanation on why the medication was held on the back of the resident’s medication record. The staff should then complete a medication request and fax it to the pharmacy and make the nurse aware that the medication had been ordered. They

stated staff had to go through the steps when a medication needed to be refilled, and staff cannot just mark off a medication as given if the medication had not been available to give. They reveled when staff initials were not circled on the medication sheet, the medication was given to the resident as prescribed by the provider.
Staff F Medical Provider was left a message for a callback on 05/03/2023 at 12:30 p.m. however, the provider did not call back.

Based on observation, interview, and record review, the allegation that the resident was placed into isolation was unsubstantiated The resident was part of an Elopement Drill, and was never isolated by self.

Conclusion / Action:

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

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PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2578	Compliance Determination # 23322
Plan of Correction	Deer Ridge Memory Care Community	Completion Date
Page 1 of 5	Licensee: Puyallup Memory Care LLC	05/11/2023

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 05/02/2023 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): 75107

The following sample was selected for review during the unannounced on-site visit: 7 of 50 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Marilyn Klotz
Rebecca Kane, Regional Administrator
Jody Just, Field Services Administrator
Curtis Bruer Jr
Sheila Scott

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 — 5/15/2023 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) 5.16.23 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

(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, record review, and policy review, the facility failed to receive their medications as prescribed for 1 of 5 residents (Resident 1). This failure placed the resident at risk by not receiving medications as prescribed for Glaucoma.

Findings included...

Admissions records stated
Resident 1 was admitted to the facility on [redacted] 2022 with diagnoses including [redacted] and [redacted].

Review of the policy and
procedure titled, "Medication Pharmacy Procedures" no date, stated, "Administering- All drugs will be dispensed in a manner compliant with the prescribed procedure. The nurse will be responsible for preparing, administering, and recording medications. Charting of Medications- The nurse administering the medication must also assume the responsibility for charting the drug. Charting medications must be kept current and completed directly with the administration of the drug."

An observation of Resident
1 on 05/02/2023 at 9:35 a.m. revealed the resident eating breakfast in the dining area amongst other residents and staff. The resident was pleasant, and alert to self only. The resident was not interviewable.

A telephone interview with
Family Member A on 05/03/2023 at 8:42 a.m. revealed they were concerned that Resident 1 had not received the prescribed eye drop medication Latanoprost for glaucoma. The family member went onto state they had noticed staff giving Resident 1 evening eye drops; however, they were not in the same-colored vial as the previously administered Latanoprost. They revealed they had confirmed with their family member's pharmacy and had been informed the Latanoprost eye drops had only been sent to the facility in June 2022, and again in March 2023.

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Order Form" dated, 05/03/2022, revealed the initial order for Latanoprost 1 drop to each eye daily.

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the Staff B contracted pharmacist on 5/2/2023 at 2:50 p.m. revealed the pharmacy had sent Resident 1's Latanoprost eye drops to the facility on 06/19/2022, and not again until 03/08/2023. The pharmacist stated each vial of the eye drops had enough medication for 50 doses, or 25 days. They went onto state Latanoprost was most often given to patients with glaucoma.

Review of the
"Routine Orders" revealed staff had documented the eye drops had been administered to Resident 1 during the months of July through December 2022 and January through February as well as March 1st through March 7th, 2023.

Interview with the Staff C
Director of Resident Services on 05/03/2023 at 8:45 a.m. revealed they would have drawn the same conclusions as the family member regarding Resident 1's eye drops not being properly administrated by the staff. They stated staff signage of their initials on the medication sheet confirmed the medication had been given, and staff initials with a circle around the initials indicated the medication had been held. The Director of Resident Services revealed staff should have ordered additional eye drops from the pharmacy. They went onto state he/she had passed medications occasionally, however, he/she had not been notified by the staff or the family that the medication had been marked as given, when in fact it appeared the medication had not been available on the medication cart. They stated staff should administer medications to the residents per the physician's order.

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Certified Nursing Assistant/Medication Technician on 05/03/2023 at 10:19 a.m. revealed whenever a medication was not available to administer to a resident, the staff should circle their initials, and write a brief explanation on why the medication was held on the back of the resident's medication record. The staff should then complete a medication request and fax it to the pharmacy and make the nurse aware that the medication had been ordered. They stated staff had to go through the steps when a medication needed to be refilled, and staff cannot just mark off a medication as given if the medication had not been available to give. They reveled when staff initials were not circled on the medication sheet, the medication was given to the resident as prescribed by the provider.

Staff F Medical Provider
was left a message for a callback on 05/03/2023 at 12:30 p.m. however, the provider did not call back.

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) 6.29.23.

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

Administrator (or Representative) Shaneka Gz Date 5.16.23