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) 45425 (Completion Date 08/19/2024) and 37207 (Completion Date 05/24/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/19/2024 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3

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)254-3190.

Sincerely,

Cory Cisneros, 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 #: 37207
Investigator: Carol Gijima
Investigation Date(s): 02/22/2024 through 05/24/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 118678
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Resident sustained fracture after a fall.

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions
Interviews:	Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports,

Investigation Summary:
1. Per record review, interviews with resident's representatives and staff, the facility failed to thoroughly investigate resident falls. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/24/2024.

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: Deer Ridge Memory Care Community
License/Cert.#: 2578
Compliance Determination #: 37207
Investigator: Carol Gijima
Investigation Date(s): 02/22/2024 through 05/24/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 112137
Region/Unit #: RCS Region 3 / Unit D

Allegation(s):
1. Injury of unknown source

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions
Interviews:	Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports, Facility Abuse-Neglect policy

Investigation Summary:
1. Per record review, interviews with resident's representatives and staff, the facility failed to thoroughly investigate when a resident had a fracture of unknown origin. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/24/2024.

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: Deer Ridge Memory Care Community
Provider Type: Assisted Living Facility
License/Cert.#: 2578
Intake ID: 124265
Compliance Determination #: 37207
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 02/22/2024 through 05/24/2024
Complainant Contact Date(s): 05/20/2024

Allegation(s):

1. Failure to follow the current service plan regarding showering.
2. Fall not investigated
3. Residents not receiving care due to COVID-19 isolation to rooms
4. Surfaces not cleaned properly

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions
Interviews:	Resident representatives Staff
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports,

Investigation Summary:

1. Complaint already investigated and facility is currently out of compliance. See Statement of Deficiency dated 02/06/2024. No additional citations written.
2. Per record review, interviews with resident's representatives and staff, the facility failed to thoroughly investigate resident's fall. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 05/24/2024.
3. Per observation, record review, interviews with resident representatives and staff, there was not sufficient information to either support or refute this allegation.
4. Per observation, record review, interviews with resident representatives and staff, there was not sufficient information to either support or refute this allegation.

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 02/22/2024 and 02/22/2024 of:

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

This document references the following complaint number(s): 118678, 112137, 111351, 109868, 124265, 122118

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

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 — 06/05/2024 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;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on records review and interviews, the Assisted Living Facility (ALF) failed to conduct an investigation that determined the circumstances of the events, and institute measures to prevent future incidents when residents sustained falls and injury of unknown source for 3 of 4 sampled residents (Residents 1, 2 and 3). This failure contributed to Resident 1 sustaining two falls with fractures, requiring surgery and hospitalization, Resident 2 not having preventative measures in place, and Resident 3 at risk for abuse and continued harm.

Findings Included…

Record review of the facility's investigations and residents' records on 02/22/2024, 05/03/2024 and 05/15/2024 showed the following:

Resident 1
Record review of facility's investigations showed that Resident 1 (R1) sustained falls on the following days: 01/11/2024, 01/30/2024, 02/11/2024. Further review showed that on 01/11/2024, R1 was found on the floor in her room. The investigation stated that the nurse was to ensure that the motion sensor was always on. There was no investigation or documentation to what could have contributed to her fall or why the sensor had not been on prior to the fall. On [redacted]/2024, R1 fell and was found on the floor in her room; R1 sustained a left hip fracture and was sent to the hospital. There was no investigation or documentation to what could have contributed to her fall. There was no update to care plan or interventions upon resident's return to the facility on [redacted]/2024 to prevent recurrence. On 02/11/2024, R1 had a fall and sustained a second fracture to the right hip fracture and was sent to the hospital. There was no documentation of what may have caused the falls and no documentation that the facility instituted measures to prevent future falls.

During an interview on 02/22/2024 at 10:02am, Staff C, Resident Care Coordinator stated that R1 had a fall which resulted in a hip fracture, came back to facility, and had another fall with a second fracture to the other hip. When asked if there were interventions in place to prevent the falls, Staff C stated that they had hourly checks. When asked what the causes of the falls were, Staff C stated they were not sure but that R1 had been ambulatory with a walker and forgot to ask for help. Staff C stated that injuries of unknown source were reported to Staff B (Director of Residential Services) and investigated. When asked what had caused R3's fracture, Staff C stated that they "still don't know what caused it." When asked if the incident was investigated, Staff C stated that there should have been an investigation done.

During an interview on 02/22/2024 at 10:26am, Staff B stated that R1 had frequent falls. When asked the findings of the multiple fall investigations and interventions, Staff B stated that it was because of her "dementia," that R1 was on alert and R1 forgot that she couldn't get up by herself.

During an interview on 04/29/2024 at 3:57pm, R1's representative (RR1) stated that he was not aware of the circumstances surrounding the falls. RR1 stated falls were back-to-back and R1 broke each hip with each fall. RR1 stated that there was nothing "put in place" to prevent falls. RR1 stated that when R1 returned to the facility after the [redacted]/2024 fall, they didn't state that she was a high risk for another fall; that they took R1 back from the hospital and "never communicated anything that they were doing."

During an interview on 05/15/2024 at 2:18pm, R1's representative (RR4) stated that the facility did not know what could have contributed to her falls. RR4 stated that the staff "were not sure and assumed she tripped on something." RR4 stated when R1 had the second fall where she broke the second hip, the ALF stated that R1 forgot that she was not supposed to get up by herself and fell. When asked if there were any interventions to prevent the falls, RR4 stated "not that I am aware of." RR4 stated that staff stated they would keep R1 at the nurse's station after the first fracture, but R1 sustained the second fall in the "little dining room" which resulted in another fracture. RR4 stated that "they were not keeping her at the nurse's station."

Resident 2
Resident 2 (R2) was admitted to the facility on [redacted]/2022 with diagnoses to include [redacted]. A negotiated service plan (NSA) dated 02/25/2024 showed that R2 needed two staff for total help during showers; one staff to provide bathing and the other for safety, and both staff needed to be available for the shower assistance.

Record review of the ALF's investigations showed that R2 sustained a fall on 03/22/2024. The staff's witness statement showed that R2 was agitated and fell while staff was trying to get her out of the shower room. Staff's statement showed that they called the nurse after R2 landed on her right side. The staff witness statement and investigation did not show that there was a second staff person during showers. The investigation did not determine the circumstances of the events or institute measures to prevent future incidents from

occurring.

During a separate interview on 05/14/2024 at 10:32am, Staff A was asked about R2's fall, Staff A stated that R2 was found by the nurse lying on the floor not responding to stimulation, that it was an unwitnessed fall. When asked if the incident was investigated because the events did not match the witness statement, Staff A stated a nurse had investigated it. When asked why there was only one staff member present for the resident's shower when the care plan stated R2 needed two staff for showers, Staff A stated that R2 was not a two person for showers. Staff A stated that it was documented that way per resident's representative request for safety reasons.

During an interview on 05/03/2024 at 1:22pm, R2's representative (RR2) stated that the ALF notified her that R2 had fallen in the shower. RR2 stated that when she asked about what happened, she was told that R2 was screaming then slipped and fell, and the staff member was not able to catch her. RR2 stated the ALF had inconsistent information about what happened. RR2 stated they notified her that R2 had been found on the floor in her room and then in the shower. RR2 stated she asked why there was only one staff member giving R2 a shower when R2 was a two person with showers.

Resident 3
Resident 3 (R3) was admitted to the ALF on [redacted]/2021 with diagnoses to include [redacted]. Record review of the NSA dated 05/11/2023 showed that R3 had no aggressive behaviors that placed her at risk for injury to self. Record review of the ALFs investigations showed that on 12/22/2023, R3's friend notified facility that R3 had some swelling to left hand and fingers. The investigation stated that R3 "wanders around the unit," and there was no "evidence of abuse and neglect noted." There was no documentation of causes that could have contributed to the injury of unknown source or how the ALF ruled out abuse and neglect. The investigation did not determine the circumstances of the events or institute measures to prevent future incidents from occurring.

During an interview on 02/22/2024 at 10:26am, Staff B stated that R3 "is a wanderer," when asked about the circumstances surrounding her wrist injury. When asked where the investigation was, Staff B stated, "good question, I didn't investigate it." Staff B was asked how they would know if someone was abusing R3 if injuries of unknown source were not investigated. Staff B stated that the staff checked on residents every 24 hours, "so we know that no one abused them." When asked if another resident or person twisted R3's hand, Staff B stated that he didn't know, "but I know nobody twisted her arm and she is up all day." When asked if staff were interviewed or knew what could have happened, Staff B stated he didn't know.

During an interview on 02/22/2024 at 11:09am, Staff A, Administrator stated that resident incidents were investigated by Staff B and reported to the State if needed. When asked about R1's falls, Staff A was not able to give specific interventions. Staff A stated that interventions should be under enhanced services on the care plan. Staff A was asked about R3's injury of unknown source and how they ruled out abuse. Staff A stated that Staff B was responsible for investigations and reviewing the incidents with the regional nurse.

During an interview on 04/29/2024 at 1:36pm, R3's representative (RR3) stated that they were not sure how R3 sustained the fracture to her hand. RR3 stated that R3's friend notified the staff and when he asked about the incident, no one at the ALF seemed to know what happened or what could have caused the fracture.

This is a recurring deficiency previously cited on 05/19/2023, 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