STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Kadie Glen Assisted Living LLC
Kadie Glen Assisted Living
451 North Baker Ave
East Wenatchee, WA 98802

RE: Kadie Glen Assisted Living License # 2580

Dear Administrator:

This letter addresses Compliance Determination(s) 43133 (Completion Date 06/25/2024) and 37223 (Completion Date 05/02/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/25/2024 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-i, WAC 388-78A-2140-1-a-ii, WAC 388-78A-2140-7, WAC 388-78A-2660-4, WAC 388-78A-2120-1, 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-2120-2, WAC 388-78A-2120-2-a, WAC 388-78A-2120-2-b, WAC 388-78A-2120

The Department staff who did the on-site verification:
Brittney Shull, Community Complaint Investigator

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Kadie Glen Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2580
Intake ID: 119232
Compliance Determination #: 37223
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 02/22/2024 through 05/02/2024
Complainant Contact Date(s):

Allegation(s):

1) The named resident was admitted to the hospital then discharged by the facility after being falsely accused of drinking alcohol.
2) There are concerns for poor hygiene or shower help for the named resident.
3) There is an ant infestation in the building.
4) The named resident was refused food by the facility cook.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 1 Closed records sample size: 3
Observations:	Environment, Staff to resident interactions, Resident to resident interactions, Resident Appearance, Smoking area, Resident Rooms, Dining Room.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Incident Report and Investigation, Resident records, Facility Policy, Medical Records, Shower Log, Progress Notes, Pest Reports, Medication Administration Record (MAR), Disclosure of Services.

Investigation Summary:

1) Interview and record review showed that the named resident was discharged from the facility after they were admitted to the hospital, not related to drinking alcohol. It showed that multiple residents had been discharged immediately after admitting to the hospital. It showed that the facility did not make all required notifications or follow their policy for the named resident's health concerns. It showed that the named resident's Negotiated Care Plan (NCP) did not address their assessed needs. Failed practice identified, reference Statement of Deficiency for WAC 388-78A-2660, WAC 388-78A-2120, WAC 388-78A-2140.
2) Observations showed that residents were clean and well groomed. Interview and record review showed that residents received their showers unless they were refused. It also showed that the named resident refused showers. Failed practice was not identified.

3) Observations showed that there were no ants or other infestations in the facility. Interview and record review showed that the facility had a recent pest inspection that did not identify any concerns. Failed practice was not identified.
4) Allegation already reviewed; reference Statement of Deficiency for WAC 388-78A-2660 and WAC 388-78A-2300.

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: Kadie Glen Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2580
Intake ID: 123357
Compliance Determination #: 37223
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 02/22/2024 through 05/02/2024
Complainant Contact Date(s):

Allegation(s):
The named resident eloped from the facility and it was not reported to the department.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 1 Closed records sample size: 3
Observations:	Environment, Staff to resident interactions, Resident to resident interactions, Entrance/Exits.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Incident Report and Investigation, Resident records, Facility Policy, Medical Records, Sign In/Sign Out record, Progress Notes, Assessment and Care Plan, Disclosure of Services.

Investigation Summary:
Interview and record review showed that the named resident had left the facility and was not accounted for until it was discovered that the named resident had admitted to the hospital. It showed that the facility did not follow their policy for a missing resident and the named resident's Negotiated Care Plan (NCP) did not address their assessed needs. Failed practice identified, reference Statement of Deficiency for WAC 388-78A-2600 and WAC 388-78A-2140.

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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2580	Compliance Determination #37223
Plan of Correction	Kadie Glen Assisted Living	Completion Date
Page 1 of 17	Licensee: Kadie Glen Assisted Living LLC	05/02/2024

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 02/22/2024, 03/13/2024 and 02/22/2024 of:

Kadie Glen Assisted Living
451 North Baker Ave
East Wenatchee, WA 98802

This document references the following complaint number(s): 119232, 120114, 123357

The following sample was selected for review during the unannounced on-site visit: 1 of 61 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

05/15/2024
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) 5/24/2024 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:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement their policy and procedure to supervise and account for residents who left the facility premises for 1 of 1 resident (Resident 3). This failure resulted in a delay of a search for Resident 3, a delay in an investigation by the department, and placed the resident at risk for harm.

Resident 3

Review of the facility's undated policy titled, "Resident Absence/Missing Resident," showed that the facility would monitor residents who left the facility and would have a general knowledge of their whereabouts. Residents should sign in and out of the facility and if a resident was gone more than four hours past their expected return, the facility was to initiate a search and if the search was unsuccessful, contact local law enforcement. The policy showed that if a person was missing, staff should notify the facility registered nurse (RN) or administrator, search the grounds for the resident, notify family, law enforcement and other agencies required by law, and document the actions taken.

Review of Resident 3's record showed the resident was admitted to the facility on [redacted]/2024 and had a diagnosis of [redacted], and [redacted].

Review of Resident 3's Assessment and Care Plan (NSA, the facility's titled negotiated service agreement), dated [redacted]/2024, showed that Resident 3 used a wheelchair independently, could make their own decisions, and scored low on an elopement (leaving the facility) assessment. The NSA did not indicate if the resident was safe to leave the facility without supervision or how staff were to monitor or account for the resident while they were off the premises.

Review of the facility's Resident Sign out/Sign in Sheets, dated [redacted]/2024 thru [redacted]/2024, showed that Resident 3 left the facility nearly every day from [redacted]/2024 to [redacted]/2024. The document showed that Resident 3 typically signed back in between the

hours of 1:00 PM and 4:00 PM. The document further showed that on [redacted]/2024, Resident 3 signed out at 9:10 AM and did not sign back in that day. The Resident Sign out/Sign in Sheets did not show a column for an expected return time and did not show that any resident had documented an expected return time on the sheets.

Review of Resident 3's progress notes, dated [redacted]/2024, showed the resident left the facility at 9:30AM on [redacted]/2024 and stated they were headed to a local soup kitchen, food dispensary and emergency shelter. The progress note stated that Resident 3 did not return the evening of [redacted]/2024 and that the facility RN was not notified until 6:30AM on [redacted]/2024 (the following day). Further review of the note showed the RN had searched the local electronic medical records and found that Resident 3 had been admitted to the hospital.

Review of Resident 3's incident report, dated [redacted]/2024, showed the resident left the facility on [redacted]/2024 at 9:30AM. The report showed that the resident was found next to their wheelchair and was brought to an emergency room in poor health. The report did not indicate who found the resident or if a search had been conducted to find the resident.

Review of Resident 3's hospital medical records, dated [redacted]/2024 thru [redacted]/2024, showed that Resident 3 was found unresponsive on the ground, next to their wheelchair and was taken to the emergency room.

In an interview on 03/13/2024 at 11:29AM, Staff E, Director of Nursing Services, stated that on [redacted]/2024, Resident 3 left at 9:30AM and did not come back to the facility by the time they (Staff E) had gotten off work that day at around 5:00 PM. Staff E stated that at that time, they had started to worry but would not have considered Resident 3 missing until after 24 hours as the resident was alert and oriented. Staff E stated that when they returned to the work on [redacted]/2024, they were alerted that Resident 3 had still not returned to the facility, so they checked the local hospital electronic medical records and discovered that Resident 3 had been admitted to the hospital on [redacted]/2024 at 8:30PM. Upon reading the facility policy titled, "Resident Absence/Missing Resident," Staff E stated, they did not know the facility was supposed to initiate a search for the resident after only four hours past their expected return.

Review of the department's reporting database, on 03/13/2024, showed that no report had been made to the department regarding a missing resident.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/16/24 .

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

Administrator (or Representative) — Date: 5/24/24

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(7) The resident's ability to leave the assisted living facility premises unsupervised; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to document in the negotiated service agreement, a plan that addressed and supported a resident's ability to leave the facility unsupervised or a plan to address interventions for individualized health risks identified in the assessment for 2 of 4 residents (Resident 1, 3). This failure resulted in Resident 3 being unaccounted for and placed them at risk for deteriorating health, Resident 1 having unrecognized and untreated malnutrition, and placed the residents at risk for unmet needs.

Findings included...

Review of the facility's undated policy titled, "Resident Absence/Missing Resident," showed that the facility intended to monitor residents who left the facility and have a general knowledge of their whereabouts.

Review of the facility's Disclosure of Services showed that the facility building was unsecured, and residents could come and go as they saw fit.

Review of the facility's undated policy titled, "Protocol Low Blood Sugar," showed that if blood sugars were under 70, staff should give the resident four oz (ounces) of juice and repeat testing 15 minutes later. The policy then instructed staff to repeat the process if the blood sugar was still under 70. The policy instructed staff to provide a snack or meal if the blood sugar was above 70. The policy showed that if for a third time, the blood sugar was still under 70, the staff should call Emergency Medical Services (EMS). The policy showed that all blood sugars should be recorded and instructed staff to notify physicians for all blood sugars under 60 and for trends of blood sugars under 80. The policy instructed staff to notify the Registered Nurse Delegator (RND) for all blood sugars under 70 and for trends

of blood sugars under 80 (frequent, more than occasional). The policy instructed staff to call 911 for all blood sugars under 55.

Resident 3

Review of a document titled, Resident Information, showed that Resident 3 was admitted to the facility on [redacted]/2024 and was diagnosed with [redacted] and [redacted].

Review of Resident 3's Assessment and Care Plan (NSA, the facility's titled negotiated service agreement, dated [redacted]2024, showed that Resident 3 used a wheelchair independently. The NSA also showed that Resident 3 could make their own decisions and scored low on an elopement assessment. The NSA did not indicate if the resident was safe to leave the facility without supervision, how to account for the resident, or when to expect the resident to return to the facility. The NSA showed that Resident 3 was diagnosed with [redacted] and to monitor and report an abnormal blood sugar (a measurement of sugar in the blood). The NSA did not instruct staff on what to do in the event of an abnormal blood sugar beyond reporting it, although it did not specify who staff were to report to. The NSA did not specify that there was an available policy to follow with actions to correct low blood sugar. The NSA showed that Resident 3 had missing teeth, although it did not show any interventions or plan to address any needs related to missing teeth. The NSA further showed that Resident 3 smoked cigarettes and had a history of alcohol use, although it did not show any plan to monitor cigarette or alcohol use, or an assessment of the resident's ability to safely smoke.

Review of Resident 3's Medication Administration Record (MAR) for February 2024, showed that Resident 3 required blood sugar checks and received insulin injections (a medication used to lower blood sugar in diabetics). Further review of the MAR showed the resident often missed blood sugar testing (which was not identified in the NSA).

Review of the facility's Resident Sign out/Sign in Sheets showed that Resident 3 left the facility on [redacted]2024 at 9:10AM and did not sign back in.

Review of a progress note, dated [redacted]/2024, showed that Resident 3 left the facility at 9:30AM on [redacted]/2024 and did not return that evening or night. The note showed the facility's registered nurse was notified at 6:30 AM on [redacted]/2024, at which time they were able to locate the resident at a local hospital.

In an interview on 03/13/2024 at 11:29AM with Staff B, Executive Director, and Staff E, Director of Nursing Services, Staff B, Executive Director, stated that they knew resident care plans and assessments should reflect a resident's ability to safely leave the facility unsupervised. Staff B further stated they had not ensured this requirement had been completed for all residents.

In an interview on 03/13/2024 at 11:29AM, Staff E stated that Resident 3 had left the facility on [redacted]/2024 at 9:30 AM and was later notified on the morning of [redacted]/2024 , that the resident had not returned to the facility. Staff E stated they located the resident at the local hospital. Staff E stated the resident had been admitted to the hospital due to health concerns after the resident was found sitting in the street next to their wheelchair and appearing unwell.

In an interview on 03/13/2024 at 11:38AM, Staff C, Medication Technician, stated that the blanks for the blood sugar checks on the February 2024 MAR, and the letters, "OOF," meant that that Resident 3 was out of the facility and did not get their blood sugar taken when it was due.

Review of Resident 3's hospital medical records dated, [redacted]/2024 thru [redacted]/2024, showed that Resident 3 was found unresponsive on the ground, next to their wheelchair and brought to the emergency room.

Resident 1

Record review of a document titled, Resident Information, showed that Resident 1 was admitted to the facility on [redacted]/2023 with the medical diagnoses of [redacted] and [redacted].

Review of Resident 1's NSA, dated [redacted]/2023, showed that Resident 1 had dentures but did not use them consistently. The NSA did not include instruction for staff to assist with dentures, interventions for any complications related to oral care, or a plan for a modified diet for difficulty eating. The NSA showed the resident did not regularly come to the facility dining for meals. The NSA did not include a plan to address nutritional needs. The NSA showed the resident was not compliant with blood sugar protocol, although there were no interventions for how staff should address the noncompliance. The NSA showed the resident had difficulty falling asleep, although there were no interventions to aid the resident. The NSA showed the resident was diagnosed with [redacted]. The NSA did not include interventions or a plan to monitor the resident for weight loss, poor appetite, nausea, or digestive problems. The NSA did not address if the resident was safe to leave the facility unsupervised.

Review of Resident 1's hospital medical records, dated [redacted]/2024 thru [redacted]/2024, showed the resident had been admitted to the hospital for encephalopathy (brain disorder causing confusion from metabolic disturbances) related to low blood sugar with a level of 42 (normal 70-125), and acute renal failure (an injury to the kidneys resulting in decreased kidney function), after decreased oral intake for one week. The record showed that Resident 1 was likely over treated for their diabetes as Resident 1 had severe weight loss of 18.9% (35 pounds) over five months with chronic inadequate oral intake. The record showed that Resident 1 was diagnosed with [redacted] and [redacted]. The records also showed that Resident 1 had been over treated for their hypothyroidism (underactive

thyroid) by receiving the wrong dosage (higher than ordered) of Synthroid (a medication used to treat low thyroid hormone) for five months, which could have contributed to their weight loss.

In an interview on 02/16/2024 at 11:27AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 had been admitted to the hospital for low blood sugar on [redacted]/2024. CC1 stated that Resident 1 had an odd sleep schedule and would often only attend meals at dinner. CC1 stated that Resident 1 had dentures but could not always wear them to eat because they were ill-fitting. CC1 stated that Resident 1 told them that when their blood sugar was low, staff did not offer a snack. CC1 stated that Resident 1 would go to the dining room and ask to mix and match items from the two meal options that were soft enough to eat without dentures and had been told it was not allowed, and to pick one option or get nothing. CC1 stated that they were told by Resident 1 that they were upset and confused about how they were supposed to manage their low blood sugar.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/16/24.

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

Administrator (or Representative) — Date: 5/24/24

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

(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 interview and record review, the facility failed to adhere to discharge requirements for 3 of 3 residents (Resident 1, 2, and 3) who were not appropriately assessed for return to the facility following a hospital stay. This failure resulted in the loss of residence for Resident 1, 2, and 3 and placed facility residents at risk for improper discharge.

Findings included...

RCW 70.129.110 states that the facility must permit the resident to remain in the facility and not discharge the resident unless it is necessary for the resident's welfare, needs cannot be met in the facility, the health or safety of individuals in the facility is

endangered, or the resident has failed to make required payment for their stay. An immediate notice may be given if the health and safety of individuals are endangered or if there are urgent medical needs. Before a resident can be discharged, the facility must first attempt through reasonable accommodations to avoid the transfer or discharge and provide sufficient preparation to ensure a safe and orderly discharge from the facility.

Review of the facility's policy titled, "Residency, Transfer and Discharge," dated 12/2023, showed that residents are only transferred or discharged when it is necessary for their welfare and needs cannot be met, their safety is endangered, or if the resident had failed to pay rent.

Review of the facility's undated policy titled, "Reasonable Accommodation," showed that residents would be reasonably accommodated so they may reside as long as possible in the community and be evaluated on a case-by-case basis.

Review of the facility's Disclosure of Services, showed that the facility must attempt to reasonably accommodate resident needs before requiring them to move out. Residents may be allowed to remain in the facility if the illness is short term with an expected recovery less than 14 days. It showed that the facility provided one-person physical assistance with transfers and activities of daily living, delegated diabetic (relating to the diagnosis of [redacted]) task, and administering insulin injections (medication used to lower blood sugar).

Review of the facility's undated policy titled, "Protocol Low Blood Sugar," showed that if blood sugars were under 70, staff should give the resident four oz (ounces) of juice and repeat testing 15 minutes later. The policy then instructed staff to repeat the process if the blood sugar was still under 70. The policy instructed staff to provide a snack or meal if the blood sugar was above 70. The policy showed that if for a third time, the blood sugar was still under 70, the staff should call Emergency Medical Services (EMS). The policy showed that all blood sugars should be recorded and instructed staff to notify physicians for all blood sugars under 60 and for trends of blood sugars under 80. The policy instructed staff to notify the RND for all blood sugars under 70 and for trends of blood sugars under 80 (frequent, more than occasional). The policy instructed staff to call 911 for all blood sugars under 55.

In an interview on 02/22/2024 at 11:06AM, Staff A, Regional Administrator, stated that Residents 1, 2 and 3 had all been discharged within the last 30 days after they were transferred to the local hospital.

Record review of Resident 1, 2, and 3's Discharge Notice showed that:

-Resident 2 was discharged on [redacted]/2024 to the hospital.
-Resident 1 was discharged on [redacted]/2024 to the hospital.
-Resident 3 was discharged on [redacted]/2024 to the hospital.

Resident 2

Review of a facility document titled, Resident Information, showed Resident 2 was admitted to the facility on [redacted]/2024 and was diagnosed with [redacted], and [redacted].

Review of Resident 2's Assessment and Care Plan (NSA, the facility's titled negotiated service agreement), dated [redacted]/2024, showed that the resident was able to use a wheelchair independently and transfer themselves between surfaces. The NSA showed that Resident 2 required assistance with repositioning in bed, bathing, toileting, and dressing. The NSA further showed that Resident 2 fell on 02/09/2024 and twice on 02/11/2024.

Review of Resident 2's progress notes showed that Resident 2 began needing two-person assistance to transfer from the bed to the wheelchair on 02/05/2024. On 02/11/2024 the progress notes showed that Resident 2 had been sent to the emergency room for increased blood sugars, was diagnosed with a [redacted] on [redacted]/2024, given a dose of Keflex (an antibiotic), and sent back to the facility.

Review of Resident 2's emergency room After Visit Summary, dated [redacted]/2024, showed that Resident 2's elevated blood sugar levels were likely due to a UTI. The summary showed an order for Resident 2 to start Keflex, four times a day for five days.

Review of Resident 2's Medication Administration Record (MAR) for February 2024 showed that Resident 2 did not have Keflex scheduled. The MAR showed no documentation that Resident 2 received any Keflex from the facility.

Review of Resident 2's progress notes showed that on [redacted]/2024 Resident 2 was weak, incontinent, and resisting assistance that evening so Emergency Medical Services (EMS) were summoned, and Resident 2 was taken back to the hospital. The progress notes showed that on [redacted]/2024 Resident 2 was issued a discharge notice at the hospital (without the required 30-day notice and less than 14 days of an acute illness). The discharge notice stated the resident's needs were not being met and their level of acuity was higher than their assessment indicated.

Review of Resident 2's Discharge Notice, dated [redacted]/2024, showed the resident required constant two-person assistance which was outside the scope of the facility's disclosure of services and that the facility was issuing an immediate notice of discharge as reasonable accommodations had been attempted and the resident had not yet resided in the facility for 30 days. The discharge notice showed that Resident 2 was discharged to the hospital.

Review of Resident 2's hospital records, dated [redacted]/2024 thru [redacted]/2024, showed that Resident 2 was diagnosed with a [redacted] and [redacted]. The

records showed that on 02/14/2024 Resident 2 ambulated 66 feet with contact guard assistance (one-person, hands-on assistance to prevent falls), on 02/15/2024 Resident 2 ambulated 95 feet with contact guard assistance (the resident had returned to their admission baseline of one-person assist), and on [redacted]/2024 Resident 2 was discharged home with the care of their spouse.

In an interview on 02/22/2024 at 11:44AM, Staff A, Regional Administrator, stated that they discharged Resident 2 as they required a high level of care than the facility could provide.

In an interview on 03/15/2024 at 4:21PM, Staff A stated that it would be difficult to assess if Resident 2 was demonstrating an acute or chronic need for 2-person assistance with transfers as the resident had not been in the ALF very long. Staff A further stated that they did not care if Resident had a UTI or not as they could not provide two-person assistance per their disclosure of services. When asked why the facility did not wait to reassess the resident once they had received treatment in the hospital to see if their ability to ambulate had improved, they stated that the resident had not yet resided in the facility for 30 days and they thought that meant they could discharge the resident if it wasn't working out.

Resident 1

Review of a facility document titled, Resident Information, showed that Resident 1 had admitted to the facility on [redacted]/2023 and was diagnosed with [redacted].

Review of Resident 1's NSA, dated [redacted]/2023, showed that the facility should monitor for signs and symptoms of low or high blood sugar (BS, measurement of sugar in the blood) and follow diabetic parameters (physician's order). The NSA showed that Resident 1 was not compliant with the blood sugar protocol. The NSA showed no instructions for what staff should do if Resident 1 refused to follow the protocol or who to report it to.

Review of the Resident 1's Medication Administration Record (MAR) showed that between December 2023 and February 2024 Resident 1's blood sugars trended downwards, with more and more episodes of hypoglycemia (low BS, 70) after an increase in the dose of metformin (an oral medication used to treat high blood sugar) on 01/25/2024. The February MAR showed that 6 episodes of hypoglycemia should have required intervention (notification to RND or MD, treatment of low BS), (69 and 68 on 02/04/2024, 74 on 02/06/2024, 72 on 02/08/2024, 72, 67, and 48 on 02/10/2024, 79 and 72 on 02/11/24, 71 on 02/13/24). The MAR did not show the blood sugar levels of 68 on 02/04/24, blood sugar of 67 or 48 on 02/10/2024 were retested or documented as corrected. The MAR further showed that all medications were given, and that Resident 1 did not refuse any medications, including insulin (injectable medication used to lower blood sugar).

Review of Resident 1's progress notes from January 2023 to February 2024 did not show any documentation of physician notification after 01/25/2024 for an increased trend in low blood sugar levels. The progress notes did not show any notification to the nurse

delegator (RND) until [redacted]/2024 when Resident 1 required emergent intervention (hospitalization) for hypoglycemia, at which time the RND rescinded nurse delegation.

Review of Resident 1's discharge notice, dated [redacted]/2024, showed the resident was discharged from the facility (without the required 30-day notice and less than 14 days of an acute illness) as the resident was not stable and predictable with their blood sugars and had refused insulin.

Review of Resident 1's hospital medical records, dated [redacted]/2024 thru [redacted]/2024, showed that Resident 1 had been admitted to the hospital for hypoglycemia with a blood sugar level of 42 after decreased oral intake for one week. The discharge summary stated that Resident 1 was likely over treated for their diabetes and they were discharged from the hospital with only metformin; no longer requiring insulin (or nurse delegation for insulin). The record stated that insulin was no longer needed due to Resident 1's weight. The record further showed that the facility issued a discharge notice to Resident 1 upon admission at the hospital and refused to allow them to come back the facility. The records showed that Resident 1 discharged on [redacted]/2024 in the care of a family member after attempts to find placement were unsuccessful.

In an interview on 2/16/2024 at 11:27AM, Collateral Contact (CC1), Resident Representative, stated that Resident 1 had been admitted to the hospital for low blood sugar on [redacted]/2024. CC1 stated that Resident 1 told them that when their blood sugar was low, facility staff would not help them get something to eat. Resident 1 would go to the dining room and ask to mix and match items from the two meal options that were soft enough to eat without dentures. CC1 stated the resident was told they were not allowed to mix and match food options and the resident had to pick one option or get nothing. CC1 stated that Resident 1 told them that they were upset and confused about how they were supposed to manage their low blood sugar. CC1 stated that they did not understand why Resident 1 was discharged and that the facility did not inform them of the discharge (as required). CC1 stated that hospital staff informed them that the facility told the hospital that Resident 1 was being discharged due to the resident's excessive alcohol consumption. CC1 stated that the hospital explained that alcohol use could affect blood sugar. CC1 stated that the hospital tested Resident 1's blood and no alcohol was identified, and that Resident 1 had been sober (alcohol free) for well over 20 years. CC1 stated that the only reason they could think of as to why Resident 1 was discharged, was that maybe the facility wasn't doing their job and tried to make it look like it was Resident 1's fault.

In an interview on 03/15/2024 at 4:21PM, Staff A stated that the decision to discharge Resident 1 was made in conjunction with the RND and the facility nurse. When asked why they did not wait to issue the discharge notice until after Resident 1 had been treated in the hospital, Staff A stated that due to Resident 1's non-compliance, their blood sugars were unpredictable and the RND had to rescind delegation (which was no longer needed due to the insulin being discontinued). Staff A stated that without delegation, the facility would be unable to meet Resident1's needs.

In an interview on 03/18/2024 at 12:48PM, Staff A stated that notification of Resident 1's blood sugars should have been sent per protocol to the physician and Registered Nurse

Delegator (RND).

In an interview on 04/26/2024 at 12:28PM, Collateral Contact 2 (CC2), RND, stated that the facility did not always immediately notify them of abnormal blood sugars per protocol, and that they were not able to assist the facility if they received notifications of blood sugars two days after an event.

Resident 3

Review of a facility document titled, Resident Information, showed that Resident 3 was admitted to the facility on [redacted]/2024 and was diagnosed with [redacted], [redacted], and [redacted].

Review of Resident 3's NSA, dated [redacted]/2024, showed the resident used a wheelchair independently. The NSA showed the resident could make their own decisions and had scored low on an elopement (leaving the facility) assessment. The NSA did not indicate if the resident was appropriate to safely leave the facility without supervision. The NSA showed that Resident 3 required assistance with medications, and it did not indicate that Resident 3 refused medication or treatment.

Review of Resident 3's progress notes, dated [redacted]/2024 thru [redacted]/2024, showed the resident was pleasant, had left the facility after receiving their morning medications on [redacted]/2024 and did not return until [redacted]/2024. Progress notes dated, [redacted]/2024, showed that the resident left the facility on [redacted]/2024 and had not returned that day.

Review of Resident 3's incident report, dated [redacted]/2024, showed the resident had been hospitalized on the evening of [redacted]/2024 after having been found in the community next to their wheelchair and in poor health.

Review of a Resident 3's discharge notice, dated [redacted]/2024, showed the facility discharged the resident to the hospital (without the required 30-day notice and less than 14 days of an acute illness) due to Resident 3 not being stable and predictable and failing to pay rent. It further showed that it was an immediate discharge as the resident had not resided in the facility for 30 days yet.

Review of Resident 3's hospital medical records, dated [redacted]/2024 thru [redacted]/2024, showed the resident was found unresponsive on the ground, next to their wheelchair and brought to the emergency room.

In an interview on 03/12/2024 at 10:54AM, Collateral Contact 3 (CC3), First Responder, stated that they had been concerned that the facility treated residents that they did not like, differently than the other residents. CC3 further stated that they believed the facility dumped residents at the hospital when they wanted to get rid of them.

In an interview on 03/15/2024 at 4:21PM, Staff A stated that they did not wait to see if the resident would recuperate from their hospital stay before deciding to discharge the resident.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/16/24 .

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

Administrator (or Representative) 5/24/24 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(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

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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 interview and record review, the facility failed to identify, evaluate, monitor, and take appropriate actions for patterns of hypoglycemia and weight loss for 1 of 1 resident (Resident 1). These failures resulted in hospitalization and discharge from the facility for Resident 1, and placed residents at risk of unidentified and untreated health needs.

Findings included...

Review of the facility's undated policy titled, "Medication Refusal by a Resident," showed that the facility should contact a licensed nurse to evaluate the significance of a resident refusing their medication and take appropriate action by notifying the prescriber or healthcare practitioner when there is a pattern of the resident refusing their medications. The policy further showed that a licensed nurse or designated staff person should document the resident's refusal along with the staff's response to the refusal and the practitioner's directions in the resident record.

Review of the facility's undated policy titled, "Resident Supervision and Monitoring," showed that residents would be monitored on a 24-hour basis and monitoring would be individualized based on the Negotiated Service Agreement (NSA, Assessment and Care Plan).

Review of the facility's undated policy titled, "Nurse Delegation Overview," showed that blood sugars (measurement of sugar in the blood) should be faxed weekly for two weeks after changes in insulin (medication to treat high blood sugar) orders. The policy further showed that blood sugars should be faxed more frequently, or the Registered Nurse Delegator (RND) should be called if the blood sugars were abnormal (under 70 or above 100).

Review of the facility's undated policy titled, "Protocol Low Blood Sugar," showed that if blood sugars were under 70, staff should give the resident four oz (ounces) of juice and repeat testing 15 minutes later. The policy then instructed staff to repeat the process if the blood sugar was still under 70. The policy instructed staff to provide a snack or meal if the blood sugar was above 70. The policy showed that if for a third time, the blood sugar was still under 70, the staff should call Emergency Medical Services (EMS). The policy showed that all blood sugars should be recorded and instructed staff to notify physicians for all blood sugars under 60 and for trends of blood sugars under 80. The policy instructed staff to notify the RND for all blood sugars under 70 and for trends of blood sugars under 80 (frequent, more than occasional). The policy instructed staff to call 911 for all blood sugars under 55.

Resident 1

Review of Resident 1's facility record showed the resident was admitted to the facility on [redacted]/2023 and was diagnosed with [redacted] and [redacted].

Review of Resident 1's Assessment and Care Plan (NSA, the facility's titled negotiated service agreement, dated 06/13/2023, showed that Resident 1 was diagnosed with [redacted] and instructed staff to monitor for signs and symptoms of low or high blood sugar and to follow diabetic parameters. Attached to the document was a picture and chart that described low blood sugar symptoms (irritability, confusion, shakiness, personality changes, weakness) and defined normal blood sugar as 70-140, high as above 140, and low as below 70. The document was updated with an undated handwritten note stating

that Resident 1 did not come down for regular meals. The NSA further showed that the warning signs of ulcerative colitis included digestive problems that could lead to weight loss, poor appetite, nausea, and fatigue.

Review of Nurse Delegation Instructions for Resident 1, dated 05/17/2023, showed that low blood sugar could result from the use of insulin and staff should notify the RND for medication changes, dropping or decreasing blood sugars under 60, changes in food intake, and for nausea and vomiting. The NSA showed that the physician should be notified for the same conditions.

Review of a physician's note, dated 01/25/2024, showed that Resident 1 had orders for 10 units of Lantus insulin (long-acting injected medication that lowers blood sugar) at bedtime. The note showed that Resident 1 also had Novolin Sliding Scale insulin (injected medication that lowers blood sugar in which the dose is based on the blood sugar, a sliding scale) four times a day. The physician's note instructed that the Novolin be administered as follows: 71-200 NO COVERAGE, 201-250=two UNITS, 251-300= four UNITS, 301-350= six UNITS, 351-400= eight UNITS, greater than400= 10 UNITS AND NOTIFY MD). The note showed that metformin (an oral medication used to lower blood sugar) was increased from 500mg twice a day to 1000mg twice a day.

Review of the Resident 1's Medication Administration Record (MAR) showed that:

- Between December 2023 and February 2024 Resident 1's blood sugars trended downwards.
- The resident's blood sugar measured below 60 (requiring physician notification, RND notification and treatment) on 01/13/2024, 01/31/2024, and 02/10/2024. Low blood sugars of 53 on 01/31/2024 and 48 on 02/10/2024 were treated or checked for correction (returned to normal).
- Low blood sugars (below 70 requiring treatment and RND notification): 63 on 01/15/2024, 68 on 01/25/2024, 68 on 02/04/2024, and 67 on 02/10/2024 were not treated or checked for correction.
- The MARs showed that the when the resident's blood sugars measured below 80 (requiring RND notification) on 12/05/2023, 12/31/2023, 01/10/2024, 01/13/2024, 02/06/2024, 02/08/2024, 02/10/2024, 02/11/2024, 02/13/2024 the RND was not immediately notified.
- Further review of the MARs showed that in February, the resident's blood sugars started measuring below 80 on a more frequent basis, although there was no documentation that the physician was faxed weekly. The MAR showed that Resident 1 did not refuse any medications.

Review of Resident 1's progress notes from October 2023 to February 2024 showed that weight measurements were not taken for Resident 1 with documentation stating that staff were unable to obtain the resident's weight due to the weight scale not working appropriately. The progress notes showed no documentation for any treatment of the resident's low blood sugars of 63 on 01/15/2024, 68 on 01/25/2024, 53 on 01/31/2024, 68 on 02/04/2024, and 48 or 67 on 02/10/2024 were treated or checked for correction (returned to normal). Resident 1's progress notes showed no documentation of any evaluation or action taken for the resident's low blood sugar on the noted dates or any notifications to the physician after 01/25/2024. The progress notes did not show any

notification to the RND until 02/13/2024 when Resident 1 required emergent intervention for hypoglycemia (blood sugar below 70), at which time the RND rescinded nurse delegation.

Review of Resident 1's hospital medical records, dated [redacted]/2024 thru [redacted]/2024, showed the resident had been admitted to the hospital for encephalopathy (brain disorder causing confusion from abnormal metabolism) related to hypoglycemia with a blood sugar level of 42, and acute renal failure (an injury to the kidneys resulting in decreased kidney function). The records showed this condition occurred after the resident had decreased oral intake for one week, which was reported to the hospital by facility staff (which was not documented in the resident's record). The record stated that Resident 1 was likely over treated for their diabetes and they were discharged from the hospital with only metformin. The record stated that insulin was no longer needed due to Resident 1's severe weight loss of 18.9% (35 pounds) over five months. The records showed that Resident 1 was diagnosed with [redacted]. The record showed that the facility issued a discharge notice to Resident 1 upon admission to the hospital and refused to allow the resident to return to the facility.

Review of a discharge notice, dated [redacted]/2024, showed that Resident 1 was discharged from facility.

In an interview on 2/16/2024 at 11:27AM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 did not always attend meals due to their odd sleep schedule. CC1 stated that Resident 1 had difficulty eating meals due to ill-fitting dentures. CC1 stated that facility staff did not provide food to the resident when their blood sugar was low. CC1 stated the facility did not accommodate the resident's requests for foods that were easier to chew and told the resident that if they did not like the options provided, they would get nothing. CC1 stated that the resident stated they were upset and confused about how they could treat their low blood sugar. CC1 stated they believed the facility might not have been doing their job.

In an interview on 03/13/2024 at 11:09AM with Staff C, Medication Technician, and Staff D, Staff C stated that the facility requirement to notify the RND for extreme low and high blood sugars had been in process before they started working for the ALF over a year ago. Staff D stated the notification to the physicians were documented and kept under tab two in the resident's record binder, tab 3 should contain that same information in a progress note, and RND notifications were kept in the delegation binder. Staff C further stated that the verbiage of, "diabetic parameters," in the record referred to the physician's order, and if not specified by the physician, staff should follow the RND supplied protocol to know what actions to take in the event of extreme low of high blood sugars.

Review of Resident 1's undated medical record showed no documentation of notifications to the physician or nurse delegator between the dates of 01/25/2024 (when the metformin was increased) and [redacted]/2024 (when EMS was summoned), regarding each episode of low blood sugar, the general downward trend of blood sugar levels, or a notification of the decrease in oral intake. Further review of the record showed the resident was not evaluated for the episodes of low blood sugar to determine if further action was needed.

In an interview on 03/18/2024 at 12:48PM, Staff A, Regional Administrator, stated that notification of Resident 1's blood sugars should have been sent per protocol to the physician and RND.

In an interview on 04/26/2024 at 12:28PM, Collateral Contact 2 (CC2), RND, stated the facility did not always immediately notify them of abnormal blood sugars per protocol, which made it difficult to provide guidance.

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, Kadie Glen Assisted Living is or will be in compliance with this law and / or regulation on (Date) 6/16/24.

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

Administrator (or Representative) — Date: 5/24/24