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

03/24/2025

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

RE: Kadie Glen Assisted Living # 2580

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 56796 (Completion Date 03/24/2025) and 53473 (Completion Date 01/29/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/24/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**WAC 388-78A-2210 Medication services.**

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

The Department staff who did the On Site verification:
Anna Cairns, ALF Long Term Care Surveyor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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:** 162984
**Compliance Determination #:** 53473
**Region/Unit #:** RCS Region 1 / Unit G
**Investigator:** Anna Cairns
**Investigation Date(s):** 01/23/2025 through 01/29/2025
**Complainant Contact Date(s):**

**Allegation(s):**

1. The named resident's doctor notified the facility that they could manage their medications and the facility gave the named resident their medications.
2. The named resident's psychiatric physician notified the facility that the named resident should not be allowed to manage their medications and the facility tried to get the medications back from the named resident and they stated they took the medications inappropriately.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 60<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Common areas<br>Resident rooms |
| **Interviews:** | Administrator<br>Director of Nursing<br>Staff<br>Residents<br>Residents |
| **Record Reviews:** | Characteristic roster<br>Resident records (assessments, care plans, self-medication assessments, progress notes, doctor's orders, incident reports)<br>Hospital discharge<br>Physician orders<br>Behavior health plan<br>Facility policies |

**Investigation Summary:**

1. The facility did a self-medication assessment for the named resident to determined that they could not safely manage their medications. The facility gave the named resident their medications to manage independently. Failed practice identified, WAC 388-78A-2210(1)(b).

2. The facility was notified by the psychiatric physician of the named resident not being safe to manage their medications, the facility removed the remaining medications from the named resident's possession and found that several doses of a stimulant and pain medication were missing. The resident then stated that they had taken several doses of their medications. The facility had the named resident taken to the hospital for evaluation and they were taken to a psychiatric facility for additional evaluation. Failed practice identified, WAC 388-78A-2210(1)(b).

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**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***



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 01/23/2025 of:

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

This document references the following complaint number(s): 162984, 160419, 160463

The following sample was selected for review during the unannounced on-site visit: 3 of 60 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor

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

| Statement of Deficiencies | License #: 2560 | Compliance Determination #53473 |
|---|---|---|
| Plan of Correction | Kadie Glen Assisted Living | Completion Date |
| Page 2 of 4 | Licensee: Kadie Glen Assisted Living LLC | 01/29/2025 |

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.

Laura Williams-Davis
Residential Care Services

2/12/25
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)

2/19/25
Date

**WAC 388-78A-2210 Medication services.**

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure that there was a system in place for safe medication services for 1 of 2 residents (Resident 1). This failure resulted in the resident receiving in-patient psychiatric care due to mismanagement of their medications.

Review of the facility's medication service policy, updated 12/04/2024, showed that the facility would do an assessment of the residents' ability to do their medications to determine the resident's level of independence, assistance, or need for administration based on their abilities and health and safety needs.

Review of Resident 1's demographic sheet, dated 08/21/2024, showed that the resident had diagnoses of [redacted].

Review of Resident 1's behavior support plan, dated 08/23/2024, showed that the resident should be monitored for non-compliance of medications, suicidal ideation, and intentional self-harm/injury.

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.

Laura Williams-Davis — Residential Care Services

2/12/25 — 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-2210 Medication services.**

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

**This requirement was not met as evidenced by:**

Based on observation, interview, and record review, the Assisted Living Facility failed to ensure that there was a system in place for safe medication services for 1 of 2 residents (Resident 1). This failure resulted in the resident receiving in-patient psychiatric care due to mismanagement of their medications.

Review of the facility's medication service policy, updated 12/04/2024, showed that the facility would do an assessment of the residents' ability to do their medications to determine the resident's level of independence, assistance, or need for administration based on their abilities and health and safety needs.

Review of Resident 1's demographic sheet, dated 08/21/2024, showed that the resident had diagnoses of [redacted], [redacted], [redacted], [redacted], [redacted], and [redacted].

Review of Resident 1's behavior support plan, dated 08/23/2024, showed that the resident should be monitored for non-compliance of medications, suicidal ideation, and intentional self-harm/injury.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 09/23/2024, showed that the resident required assistance for medications. Additionally, their NSA showed that the resident had hallucinations that had led to multiple hospital visits and to ensure that the resident took prescribed medications.

Review of the facility self-medication assessment that had been done previously, dated 09/23 /2024, showed that the resident was not safe to self-administer some or all of their medications.

In an interview on 01/23/2025 at 12:18 PM, Staff B, Director of Nursing, stated that Resident 1's physician had recommended that they be able to self-administer their medications. Staff B stated that they had given Resident 1 their medications on 01/09/2025 to self administer.

In an interview on 01/27/2024 at 3:30 PM, Staff B, stated that when they had received a notification from Resident 1's physician that they could take their own medications, they had not completed a new medication assessment for the resident's ability to safely self-administer their medications. Additionally, Staff B acknowledged that the last self-medication assessment that had been completed on 09/23/2024 showed that the resident took their medications inappropriately and was not safe to self-administer their medications.

In an interview on 01/23/2025 at 12:19 PM, Staff C, Medication Technician, stated that Resident 1's mental health physician had rescinded the direction of the resident self-administering their medications on the morning of [redacted]/2025. Staff C stated that staff went to retrieve the medications from Resident 1 and the resident stated that they had taken 10 doses of Adderall (stimulant medication) and 10 doses of oxycodone (pain medication), three times, in less than 24 hours. Additionally, Staff C stated that Resident 1 had been taken to the hospital and was now at a psychiatric facility.

Review of Resident 1's behavioral hospital discharge summary, dated [redacted]/2025, showed that the resident was evaluated for an intentional overdose. Additionally, the summary showed that the facility faxed paperwork that showed that the resident had in their possession, 42 oxycodone pills, 10 Adderall pills, and two cards with 30 tablets each of Adderall that were empty.

| Statement of Deficiencies | License #: 2560 | Compliance Determination #53473 |
|---|---|---|
| Plan of Correction | Kadie Glen Assisted Living | Completion Date |
| Page 4 of 4 | Licensee: Kadie Glen Assisted Living LLC | 01/29/2025 |

**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) 3/24/25.

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

Administrator (or Representative) — Date: 2/19/2025

**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)_____ .

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

_____ _____

Administrator (or Representative) Date