STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Spokane Special Care Community LLC
The Cottages of Spokane
6930 N Nevada St
Spokane, WA 99208

RE: The Cottages of Spokane License # 2591

Dear Administrator:

This letter addresses Compliance Determination(s) 52425 (Completion Date 12/31/2024) and 49509 (Completion Date 11/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/31/2024 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-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2474-2-c

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor
Patricia Eddy, Community Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Spokane Special Care Community LLC
The Cottages of Spokane
6930 N Nevada St
Spokane, WA 99208

RE: The Cottages of Spokane # 2591

Dear Administrator:

This document references the following complaint numbers 151569, 145460.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 11/07/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services

Region 1, Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(c) Ensure all menus:

(v) Provide a variety of foods; and

(vi) Are not repeated for at least three weeks, except that breakfast menus in assisted living facilities that provide a variety of daily choices of hot and cold foods are not required to have a minimum three-week cycle.

The facility had a Finger Foods Menu for residents that had limited abilities using silverware. The Finger Food Menu had numerous repeated meals within the 21-day menu cycle. Staff immediately changed the Finger Food Menu to reflect a variety of meals and agreed to continue to do so on future menus.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration

Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit B
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2591	Compliance Determination # 495639
Plan of Correction	The Cottages of Spokane	Completion Date
Page 4 of 8	Licensee: Spokane Special Care Community LLC	11/07/2024

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 the unannounced on-site full inspection and complaint investigation on 11/01/2024, 11/04/2024 and 11/05/2024 of:

The Cottages of Spokane
6930 N Nevada St
Spokane, WA 99208

This document references the following complaint numbers: 151569, 145480.

The following sample was selected for review during the unannounced on-site visit: 10 of 74 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Joy Pipgras, LTC Surveyor
Tethra Wales, Assisted Living Facility Licensor
Patricia Eddy, Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

Stephanie Jones

Residential Care Services

11/19/2024

Date

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 the unannounced on-site full inspection and complaint investigation on 11/01/2024, 11/04/2024 and 11/05/2024 of:

The Cottages of Spokane
6930 N Nevada St
Spokane, WA 99208

This document references the following complaint numbers: 151569, 145460.

The following sample was selected for review during the unannounced on-site visit: 10 of 74 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Joy Pipgras, LTC Surveyor
Tethra Wales, Assisted Living Facility Licensor
Patricia Eddy, Community Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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

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) 11/26/24 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.

(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:

(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 and record review, the facility failed to ensure medications were administered to residents as ordered by the medical provider for 2 of 10 residents (Resident 2 and 5) and failed to monitor a resident's blood pressure daily to determine if a medication should be administered or held for 1 of 10 residents (Resident 5). This failure resulted in Resident 2 not receiving needed medication and Resident 5 receiving medication that should not have been given, and placed the residents at risk for health complications.

Findings included...

< Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA), dated 11/27/2023, showed diagnoses of [redacted]. Review of the NSA showed that the facility staff were to administer medications as per physicians' orders. Further review showed that Resident 2 "will pretend to be asleep when it's time to take meds," and that when Resident 2 resisted or declined care, staff were to provide space and reapproach later.

Review of Resident 2's September 2024 and October 2024 Medication Administration

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

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medications were administered to residents as ordered by the medical provider for 2 of 10 residents (Resident 2 and 5) and failed to monitor a resident's blood pressure daily to determine if a medication should be administered or held for 1 of 10 residents (Resident 5). This failure resulted in Resident 2 not receiving needed medication and Resident 5 receiving medication that should not have been given, and placed the residents at risk for health complications.

Findings included…

< Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA), dated 11/27/2023, showed diagnoses of [redacted], and [redacted]. Review of the NSA showed that the facility staff were to administer medications as per physicians' orders. Further review showed that Resident 2 "will pretend to be asleep when it's time to take meds," and that when Resident 2 resisted or declined care, staff were to provide space and reapproach later.

Review of Resident 2's September 2024 and October 2024 Medication Administration

Records (MARs) showed that Resident 2 was to receive one tablet of divalproex (a medication used to treat seizures) once a day. The MARs showed that the resident did not receive the medication on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024, 10/30/2024, and 10/31/2024. The MAR listed the reason the medication was not given as, "resident sleeping."

Review of Resident 2's September 2024 and October 2024 MARs showed that Resident 2 was to receive one tablet of furosemide (a medication that helps rid the body of excess water) once a day. The MARs showed that the resident did not receive the medication on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024, 10/30/2024, and 10/31/2024. The MAR listed the reason the medication was not given as, "resident sleeping."

Review of Resident 2's September and October 2024 MARs showed that Resident 2 was to receive one tablet of potassium chloride (a supplement that increases the level of potassium) twice a day. The MARs showed that the resident did not receive their morning does of the medication on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024 and 10/30/2024, and 10/31/2024. The MAR listed the reason the medication was not given as, "resident sleeping."

Review of Resident 2's September and October 2024 progress notes showed no documentation of reapproach or attempts to administer the medications when the resident was no longer sleeping for the medications not given on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024 and 10/30/2024, and 10/31/2024.

In an interview on 11/04/2024 at 10:32 AM, Staff G, Director of Nursing, confirmed that the medications were not given and that re-attempts should have been made.

<Resident 5>

Review of Resident 5's NSA, dated 10/10/2024, showed diagnoses of [redacted] and [redacted]. Further review showed that facility staff were to administer medications as per physicians' orders.

Review of Resident 5's August 2024 MAR showed that Resident 5 was to take one tab of midodrine (medication that treats low blood pressure that causes severe dizziness and fainting) twice daily and to hold the medication if the resident's systolic (top number) blood pressure (BP) was greater than 130. The MAR showed that on 08/01/2024, Resident 5's systolic BP was 139 and on 08/02/2024 was 144 and that the midodrine was documented as given. Further review showed that that on 08/06/2024 Resident 5's order for the midodrine was decreased to a half a tab with the same directions to hold if their systolic BP was greater than 130. The MAR did not show documentation of blood pressure readings from 08/06/2024 until 08/27/2024 (19 days).

Records (MARs) showed that Resident 2 was to receive one tablet of divalproex (a medication used to treat seizures) once a day. The MARs showed that the resident did not receive the medication on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024, 10/30/2024, and 10/31/2024. The MAR listed the reason the medication was not given as, “resident sleeping.”

Review of Resident 2’s September 2024 and October 2024 MARs showed that Resident 2 was to receive one tablet of furosemide (a medication that helps rid the body of excess water) once a day. The MARs showed that the resident did not receive the medication on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024, 10/30/2024, and 10/31/2024. The MAR listed the reason the medication was not given as, “resident sleeping.”

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Review of Resident 2’s September and October 2024 progress notes showed no documentation of reapproach or attempts to administer the medications when the resident was no longer sleeping for the medications not given on 09/19/2024, 10/02/2024, 10/23/2024, 10/24/2024, 10/29/2024 and 10/30/2024, and 10/31/2024.

In an interview on 11/04/2024 at 10:32 AM, Staff G, Director of Nursing, confirmed that the medications were not given and that re-attempts should have been made.

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Review of Resident 5’s NSA, dated 10/10/2024, showed diagnoses of [redacted] and [redacted]. Further review showed that facility staff were to administer medications as per physicians’ orders.

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In an interview on 11/04/2024 at 10:32 AM, Staff G confirmed that the parameters had not been followed as ordered and no blood pressure readings had been documented after 08/06/2024 to note if the midodrine needed to be held.

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, The Cottages of Spokane is or will be in compliance with this law and / or regulation on (Date) 12/16/24

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

Administrator (or Representative) — Date 11/26/24

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure specialty training for dementia and mental health was completed by 2 of 5 sampled staff (Staff A and B). This failure placed residents at risk of receiving care from untrained staff.

Findings included...

Review of the facility's Characteristic Roster showed that all 76 residents residing in the facility had a diagnosis of [redacted]

Review of an undated personnel file for Staff A, Caregiver, showed they were hired on 06/24/2024. Further review showed that they had not completed specialty training for dementia.

Review of an undated personnel file for Staff B, Caregiver, showed they were hired on 03/25/2024. Further review showed that they had not completed specialty training for dementia.

In an interview on 11/04/2024 at 10:32 AM, Staff G confirmed that the parameters had not been followed as ordered and no blood pressure readings had been documented after 08/06/2024 to note if the midodrine needed to be held.

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, The Cottages of Spokane is or will be in compliance with this law and / or regulation on (Date)_____ .

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure specialty training for dementia and mental health was completed by 2 of 5 sampled staff (Staff A and B). This failure placed residents at risk of receiving care from untrained staff.

Findings included…

Review of the facility's Characteristic Roster showed that all 76 residents residing in the facility had a diagnosis of [redacted].

Review of an undated personnel file for Staff A, Caregiver, showed they were hired on 06/24/2024. Further review showed that they had not completed specialty training for dementia.

Review of an undated personnel file for Staff B, Caregiver, showed they were hired on 03/25/2024. Further review showed that they had not completed specialty training for dementia.

In an interview on 11/04/2024 at 9:25 AM, Staff F, Executive Director, stated that Staff A and Staff B had not completed the required specialty training certification within 120 days of hire.

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, The Cottages of Spokane is or will be in compliance with this law and / or regulation on (Date) 12/16/24.

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

Administrator (or Representative) 11/26/24 Date

In an interview on 11/04/2024 at 9:25 AM, Staff F, Executive Director, stated that Staff A and Staff B had not completed the required specialty training certification within 120 days of hire.

Plan/Attestation Statement

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Administrator (or Representative) Date