STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

04/01/2025

MP Smokey Point, LLC
Fields Senior Living at Smokey Point
3607 169th St NE
Arlington, WA 98223

RE: Fields Senior Living at Smokey Point License # 2601

Dear Administrator:

This letter addresses Compliance Determination(s) 57075 (Completion Date 03/25/2025) and 53450 (Completion Date 02/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/25/2025 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-2240, WAC 388-78A-2210-2-b, WAC 388-78A-2640-1-b, WAC 388-78A-2640-1-a

The Department staff who did the on-site verification:
Syng To, ALF Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kim Ripley

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Fields Senior Living at Smokey Point
License/Cert.#: 2601
Compliance Determination #: 53450
Investigator: Syng To
Provider Type: Assisted Living Facility
Intake ID: 162161
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 01/22/2025 through 02/27/2025
Complainant Contact Date(s): 01/16/2025

Allegation(s):

1) The Named Resident (NR) did not receive their pain medication for four days and the NR's representative was not notified.
2) The NR did not receive one dose of their antiseizure medication.
3) The NR received an incorrect eye drop medication for two days.
4) The NR received a blood thinner medication by error.
5) The NR had a medical event. The ALF staff did not recognize the signs.
6) The ALF was falsely documenting in the NR's records.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size: 0
Observations:	Facility Residents Staff
Interviews:	Resident's representative Residents Staff
Record Reviews:	Facility Residents

Investigation Summary:

Based on interviews and record reviews:
1) The ALF staff stated the NR did not receive their medication for seven days because it was not available. Review of Medication Administration Records (MARS) showed the NR did not receive their medication for seven days due to unavailability. A citation was issued for non-compliance with WAC 388-78A-2240 Nonavailability of medications.
2) The ALF staff stated the NR did not receive one dose of their medication. Review of MARs showed the one dose of the medication was not provided. A citation was issued for non-compliance with WAC 388-78A-2210 (2) (b) Medication Services.
3) The ALF staff stated the NR received an incorrect medication for four days.

Record reviews showed the incorrect medication was provided to the NR for four days. A citation was issued for non-compliance with WAC 388-78A-2210 (2) (b) Medication Services.
4) The ALF staff stated the medication was held as ordered by medical provider. Record reviews showed the ALF staff were aware the medication was to be discontinued. Review of MARs showed one dose of the medication was provided to the NR. A citation was issued for non-compliance with WAC 388-78A-2210 (2) (b) Medication Services.
5) The ALF staff stated they called 911 and sent the NR to hospital for evaluation when they were informed the NR was under distress. Interviews and record reviews showed the ALF did not notify the NR's primary care provider when NR was relocated to a hospital. A citation was issued for non-compliance with WAC 388-78A-2640 (1) (a) (b) Reporting significant change in a resident's condition.
6) The ALF staff stated they were aware that the medication was discontinued and that they documented the medication as provided indicating a medication error. Review of MARs showed one dose of the medication was provided to the NR after the discontinuation date. A citation was issued for non-compliance with WAC 388-78A-2210 (2) (b) Medication Services.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2601	Compliance Determination # 53450
Plan of Correction	Fields Senior Living at Smokey Point	Completion Date
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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 01/22/2025 of:

Fields Senior Living at Smokey Point
3607 169th St NE
Arlington, WA 98223

This document references the following complaint number(s): 162161

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Syng To, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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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.

Kim Ripley
Residential Care Services

03/07/2025
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.

Kimberly Manus
Administrator (or Representative)

3/10/25
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to obtain a prescribed medication for 1 of 3 residents (Resident 1). This failure resulted in Resident 1 not receiving seven consecutive doses of their pain reliever medication as ordered and placed them at risk for increased pain and medical complications.

Findings included...

Reviewed of the ALF's policy titled, "Med 03- Med Room Workflow, Refills" dated 05-05-2023, showed the ALF staff were to follow a consistent workflow to ensure medication orders and medication administration records (MARs) were up to date and refills were received in a timely manner. It was the responsibility of every staff member involved with medications to ensure the medications were ordered appropriately. Medications were to be ordered at least 7 days before running out. Should medication run out, the staff was to make a narrative entry in the chart documenting any attempts and/or the situation that led to the medication becoming unavailable. The responsible party and physician were to be contacted.

Review of face sheet dated 01/23/2025 showed Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted].

Review of negotiated service plan, dated [redacted]/2024, showed the resident required assistance for medication administration, ordering of medications and communication with the pharmacy.

Review of December 2024 MARs showed the Tramadol 50 mg 1 tablet by mouth daily at bedtime was prescribed for chronic pain. On 12/20/2024, 12/21/2024, 12/22/2024, 12/23/2024, 12/24/2024, 12/25/2024, and 12/26/2024, the MARs showed Resident 1 did not receive Tramadol. The MARs showed the code of "09" was documented for Tramadol 50 mg for all seven dates. The key code shows "09 = Other/See Nurse Notes."

Review of Resident 1's progress notes, dated from 11/10/2024 through 12/26/2024, showed no indication that pharmacy or physician contact was initiated for a Tramadol refill until 12/18/2024. The note dated 12/18/2024 showed the resident had two Tramadol left on 12/18/2024. Staff D, Medication Technician contacted the pharmacy for refill inquiry on 12/18/2024 03:15 PM.

Review of Resident 1's progress notes dated 12/25/2024, showed Resident 1's Tramadol was still unavailable, and Resident 1 had missed six days of Tramadol.

Review of a pharmacy document, dated 2025, showed 30 tablets Tramadol 50 mg was not delivered to the ALF until 12/26/2024.

On 01/22/2025 01:15 PM, Staff A, Resident Care Coordinator, stated that Resident 1 did not receive their Tramadol from 12/20/2024 until 12/26/2024 because the medication was not available. It was the ALF's staff responsibility to make sure medication was filled and delivered by the pharmacy on time. They were not sure whether the ALF staff contacted the pharmacy for refill when the medication ran low and eventually ran out. They were not sure how many days ahead the pharmacy and physician's office should be called prior to medication running out.

On 01/22/2025 02:11 PM, Staff D, Medication Technician, stated that the medication refill should be ordered seven days before they ran out. Resident 1's Tramadol was running low, and they called the pharmacy for refill on 12/18/2024. They documented the remaining quantity Resident 1 had on 12/18/2024 in progress notes.

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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, Fields Senior Living at Smokey Point is or will be in compliance with this law and / or regulation on (Date) 3/20/25 .

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

Administrator (or Representative) [signature] Date 3/10/25

WAC 388-78A-2210 Medication services.

(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 interviews and record reviews, the Assisted Living Facility (ALF) failed to correctly administer three medications for 1 of 3 residents (Resident 1) when Resident 1 did not receive an ordered medication and received two incorrect medications. These failures resulted in the resident receiving one dose of blood thinner, 13 doses of an incorrect eye medication, and did not receive one dose of antiseizure medication they were supposed to receive and placed Resident 1 at an increased risk for having medical complications.

Findings included...

Review of ALF's policy titled, "Med 03- Med Room Workflow, Signing of Medication", dated 08/22/2022 stated all staff will pour the medication each gives, verifying the medication three times during the pour process. Medications were to be administered per physician's orders.

Review of Resident 1's face sheet dated 01/23/2025 showed Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted]

[redacted].

Review of Resident 1's negotiated service plan dated [redacted]/2024 showed the resident required assistance for medication administration, ordering of medications and communication with pharmacy.

Review of the Medication Administration Record (MAR) dated December 2025 showed Resident 1 was prescribed Primidone 250 mg 1 tablet by mouth every day for seizure disorder. The MAR showed one dose of Primidone 250 mg tablet by mouth was not administered on 12/23/2024.

Review of After Visit Summary from the hospital, dated 01/06/2025, showed Resident 1's medication, Aspirin (blood thinner) 81mg was to be discontinued.

Review of the progress notes dated January 2025 showed the Resident 1 was to stop taking Aspirin 81mg upon returning to the ALF on 01/06/2025.

Review of the MAR dated January 2025 showed one dose of Aspirin 81 mg tablet was administered on 01/07/2025 09:00 AM.

Review of the After Visit document from their care provider, dated 12/31/2024, showed the Resident 1 was prescribed Preservative Free Artificial Tears at least four times a day in both eyes.

Review of the MAR dated January 2025 showed the Resident 1 received three doses of Artificial Tear Ophthalmic Solution that was not preservative free on both eyes on 01/01/2025, four doses on 01/02/2025, four doses on 01/03/2025, and two doses on 01/04/2025.

Review of Resident 1's progress notes, dated 01/04/2025, showed the resident received the eye drop that was not preservative free and medication error had occurred.

On 01/22/2025 01:15 PM, Staff A, Resident Services Coordinator, stated that the Resident 1 did not receive the Primidone 250mg on 12/23/2024.

On 01/22/2025 01:15 PM, Staff A stated that Resident 1's Aspirin 81mg was placed on hold since 01/06/2025. The resident's MAR showed it was administered on 01/07/2025 and Resident 1 received an incorrect eye drop on 01/01/2025, 01/02/2025, 01/03/2025 and 01/04/2025. It was the ALF Medication Technician's responsibility to determine whether it was the correct medication prior to administering it to the resident.

On 02/26/2025 04:18 PM, Staff C, Medication Technician, stated that Resident 1 received incorrect eye drop medication from 01/01/2025 until 01/04/2025. They took the incorrect eye drop that was not preservative free from the medication cart. Resident 1 was prescribed for preservative free eyedrop but received the eye drop that was not preservative free.

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, Fields Senior Living at Smokey Point is or will be in compliance with this law and / or regulation on (Date) 3/30/25 .

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

Administrator (or Representative) — Date: 3/10/25

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(b) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to notify and consult with the resident's physician for 1 of 3 residents (Resident 1) when Resident 1 had a change in health condition and was relocated to a hospital. This failure resulted in Resident 1's physician not being aware and not being able to provide medical care and consult for Resident 1 while Resident 1 was at the hospital.

Findings included...

Record review of the ALF's policy titled, "Clinical 03- Change in Resident status", dated 08-22-2022, showed the ALF staff have the responsibility to provide care to each resident and summon medical attention when the resident has a change in status. Examples of change would include but not limited to motor agitation, hallucinations or other unusual behavior. If there is an actual change in status or ability to function, the resident's physician should be immediately notified.

Review of Resident 1's face sheet dated 01/23/2025 showed Resident 1 was admitted to the ALF on [redacted]/2024 with multiple diagnoses including [redacted].

Review of Resident 1's negotiated service plan, dated [redacted]/2024, showed the resident required staff to report any change or decrease in functional abilities which may be indicative of pain.

Review of Resident 1's progress notes, dated [redacted]/2025, showed the resident was taken to the hospital due to crying episode and verbalization of "I don't know who I am or where I am" at 8:35 PM.

Review of After Visit Summary, dated 01/06/2025, showed the resident was hospitalized for nontraumatic hemorrhage of left cerebral hemisphere (bleeding condition within the left side of the brain that occurs without physical trauma) on [redacted]/2025.

Review of Resident 1's progress notes dated from [redacted]/2025 through 01/22/2025, showed no indication contact was initiated towards the resident's physician for the resident's hospitalization.

On 01/22/2025 01:15 PM, Staff A, Resident Service Coordinator, stated that Resident 1 was sent to the hospital by Staff B, Med Tech due to a medical emergency on [redacted]/2025 08:30 PM. There was no record showing the resident's physician was notified. They could not explain why the physician was not notified.

On 02/21/2025 04:18 PM, Staff C, Medication Technician, stated that Resident 1 was sent to the hospital due to crying episode while stating they did not know who they were and where they were at. The resident's physician was not notified.

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

Administrator (or Representative) [signature] Date 3/10/25