STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

12/09/2024

Centralia Point Operating Company LLC
Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

RE: Centralia Point Assisted Living and Memory Care # 2609

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 51356 (Completion Date 12/09/2024) and 45812 (Completion Date 08/27/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/09/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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;

The Department staff who did the On Site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager

Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 45812
Investigator: Pamela Horlick
Investigation Date(s): 08/19/2024 through 08/27/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 141548
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Report of delegating nurse not being notified when staff became aware of newly discovered wounds on resident, concern of resident not getting showers on schedule.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Nurse Delegator Med Tech Caregivers
Record Reviews:	Facility policies Care plan Progress notes

Investigation Summary:
Facility failed to notify community nurse when a resident was discovered with periarea wounds. Reporter states no concerns regarding showers being provided. Facility failed to follow policy and procedure by monitoring residents wounds when resident was placed on alert. Failed practice identified.

Conclusion / Action:

☒ 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 #: 2609	Compliance Determination # 45812
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 4	Licensee: Centralia Point Operating Company LLC	08/27/2024

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 08/19/2024 and 08/19/2024 of:

Centralia Point Assisted Living and Memory Care
2010 Cooks Hill Rd
Centralia, WA 98531

This document references the following complaint number(s): 141548

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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 — 09/04/2024 — Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Date

Bryan Bowen 9/10/24

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 policies and procedures for alert charting for 1 of 3 residents, (Resident 1 [R1]) reviewed. This failure placed R1 at risk for harm and delayed medical treatment.

Findings included...

Record review of facility policy, titled, "Alert Charting Policy," undated, stated, "Each community will have in place the following procedure to monitor residents that may be experiencing changes, either temporary or progressive changes related to general health and well-being. The following process will be used for placing and managing a resident in the Alert Charting system...A resident may be placed on Alert Charting for any reason consistent with the Alert Charting Guidelines. Any of the following team members may place a resident on Alert Charting: Administrator, RN [Registered Nurse], LPN [Licensed Practical Nuse], RCM [Resident Care Manager], Medication Aide...Resident name is place on the Alert Charting Roster and the information as to why they are being placed on alert charting is filled out...The team member who started the resident on Alert Charting will enter that information in the 24 hour log in Eldermark, initiate the TSP (Temporary Service Plan) for the resident, and place it in the TSP Plan Binder behind the residents care plan off set so that it signals that it is a new TSP...If the community is using an EHR (Electronic Health Record) the med tech will chart each shift on the status of the resident on alert charting."

Record review of facility document titled, "Alert Charting guidelines-what to chart and length of time for alert charting," undated, showed, "alert charting must occur each shift...Obtain information from each caregiver prior to the end of the shift." Under the column, titled, "Condition/Temporary Change," it showed, "Skin Issue of Any Type (Skin tear, bruise, pressure injury, rash, other wound) add to skin log, 72 hours only, RN will take over the monitoring." Under the column, titled, "what to chart," showed, "any complaints of pain, observe daily for signs and symptoms of infection, increased redness, swelling, pain, drainage, temperature, and other complaints by resident."

Record review of the facility policy, titled, "Nursing Services," undated, showed, "It is the community policy to provide specific nursing services, consistent with the community's disclosure statement/form, in order to maintain and/or enhance the health status of residents... This community provides nursing services on a limited basis, to including the following: Licensed nurses will review and respond to any incident reports or documents referring to resident incidents when there is a possibility of the need for nursing intervention (including wounds, health-based emergencies, and significant change in a resident's health condition). The community registered nurse will be consulted regarding any significant change in condition resulting from a resident incident... A licensed nurse is available in person or by telephone consistent with this community's disclosure statement regarding the provision and extent of available nursing services... Each resident's needs for nursing services will be assessed prior to admission and upon a change in condition or upon request of the resident or resident representative. Revision to or the need for nursing services will be discussed with the resident and/or representative, and case manager if appropriate, at the time of or as soon as practicable following this assessment."

Record review of R1's face sheet, dated 08/19/2024, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of R1's progress notes, dated 08/01/2024 at 10:49 PM, showed numerous areas of open wounds on R1's inner buttocks and sacral area that were uncomfortable for the resident. There was no charting completed to monitor for pain, redness, swelling drainage or any complaints from the resident on 08/02/2024, 08/03/2024, or on 08/04/2024. In an entry on 08/05/2024, showed Staff D (Registered Nurse Delegator) was first made aware of the new wound.

During a record request on 08/19/2024 at 12:53 PM, shower sheets for R1 were requested but were not provided.

In an interview on 08/19/2024 at 11:22 AM, Staff D, Registered Nurse (RN), stated they rely heavily on staff to make them aware when there was a skin issue developing on residents. Staff D stated staff were to report to them so that the wound can be addressed. They stated Staff E, Licensed Practical Nurse, was supposed to notify them. Staff D stated, "I did not receive notification."

Record review of a TSP for R1, dated 08/07/2024, showed they had skin ulcers on their bottom. Under "what to chart," showed "pain, progress toward healing, color, odor, amount of drainage or other complaints by the resident." Under "Instructions," showed, "document all shifts, treat as ordered, keep off the affected area as possible, turn and position every 2 hours, please call/report to nurse immediately if wound appears worse or resident has increased pain, have all direct caregivers read and sign this service plan."

In an interview on 08/19/2024 at 12:47 PM, Staff C, Medication Technician (Med Tech), was asked what documentation they would do if they were aware of a skin wound, they

stated, they would chart what they saw in the notes and put the resident on alert. Staff C was asked what alert means, they stated they would do full vitals, daily skin checks to assess whether the wound was healing or getting worse. Staff C was asked how long a resident with a skin wound would be on alert for, they stated, a week or until it gets better, we document on them every day regarding why they were put on alert.

In an interview on 08/19/2024 at 1:09 PM, Staff B, Resident Care Manager, was asked if R1 would have been on alert after their skin wounds were discovered, they stated, yes, R1 would have been on alert because they still had wounds that hadn't resolved.

In an interview on 08/19/2024 at 12:53 PM, Staff A, Executive Director, was asked if a new pressure wound would result in a resident being placed on alert, they stated, R1 should have been on alert until they were being monitored by the Registered Nurse.

In an interview on 08/19/2024 at 4:00 PM, Staff D, was asked if the Med Techs should be charting on the resident regarding the reason they were placed on alert, Staff D stated, yes, they should be charting on whatever caused the alert charting, there should be guidelines for the problem at hand. Staff D stated, from the date of discovery there should be alert charting done each day up until the RN gets eyes on it. Staff D stated the whole process for alert charting was not done. Staff D stated, Staff E, Licensed Practical Nurse, did not enter the information into the 24 hour log in Eldermark and did not initiate the TSP for the resident when they became aware of the wounds.

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, Centralia Point Assisted Living and Memory Care is or will be in compliance with this law and / or regulation on (Date) 10/11/2024 .

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

Andrew Barr
Administrator (or Representative)

09/10/2024
Date