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) 51357 (Completion Date 12/09/2024) and 46628 (Completion Date 09/30/2024).

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-2100 Ongoing assessments.

(1) The department amended portions of this rule from January 18, 2022, through June 8, 2023, in response to the state of emergency related to the COVID-19 pandemic. For requirements in place during that time, see WAC 388-78A-2101 .

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

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 #: 46628
Investigator: Pamela Horlick
Investigation Date(s): 09/04/2024 through 09/30/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 145364
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Report of resident being found outside of the community for an undetermined amount of time.

Investigation Methods:

Sample:
Total residents: 46
Resident sample size: 2
Closed records sample size: 1

Observations:
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions
Dining

Interviews:
Nursing staff
Residents
Family members
Kitchen staff
Activities director

Record Reviews:
State reporting log
Incident investigation
nurse assessment
Care Plan
Face Sheet
Progress Notes
Staff List
Move in/out list

Investigation Summary:
Facility failed to complete an ongoing assessment to identify a change in condition when resident was exhibiting cognitive changes. Failed practice identified.

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 #: 2609	Compliance Determination # 46628
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 6	Licensee: Centralia Point Operating Company LLC	09/30/2024

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 09/04/2024 and 09/04/2024 of:

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

This document references the following complaint number(s): 145364

The following sample was selected for review during the unannounced on-site visit: 2 of 46 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
Anissa Bearden, Licensor

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.

Cory Cisneros
Residential Care Services

10/09/2024
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) Bryce Bowen Date 10·18·2024

WAC 388-78A-2100 Ongoing assessments.

(1) The department amended portions of this rule from January 18, 2022, through June 8, 2023, in response to the state of emergency related to the COVID-19 pandemic. For requirements in place during that time, see WAC 388-78A-2101 .

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete on going assessments focused on residents identified problems, a change of condition, and when they were exhibiting cognitive changes for 1 of 3 sampled residents (Resident 1 [R1]). This failure placed R1 at risk for unmet care needs by staff untrained of the most updated care and service needs for the resident

Findings included...

Record review of the facility's policy titled, "Resident Assessment", undated, showed the facility would ensure re-assessments were completed every six months or as resident conditions and needs changed, in order to provide the most appropriate care and services. Under the section titled, "re-assessments will be completed", showed upon a change of resident condition that may alter the services and/or service levels in the facility. Information obtained for assessments and re-assessments would be gathered from the residents, family, or significant others, case managers, staff, and any other resources that may have information regarding the care needs of the resident.

Record review of the facility's policy titled, "Negotiated Service Agreements [NSA]", undated, showed the service agreements were based on assessed needs of the resident. The NSA would be updated to be consistent with the residents needs and when there had been an observed change in resident's physical, mental, or emotional function. The NSA would be updated when it no longer addressed the residents needs and/or preferences. The NSA would be implemented to meet the residents needs and preferences.

Record review of the facility's policy titled, "Alert Charting Policy", undated, showed the team member that started the resident on alert charting would enter that information on the 24 hour shift to shift report in the electronic medical records, initiate a temporary service plan (TSP), and place the TSP in the TPS binder behind the resident's care plan off set so that it signaled that a new TSP had been created and needed to be reviewed. The resident care coordinator, licensed practical nurse (LPN), or registered nurse (RN) was responsible to check the roster in each building each day. They were to review any TSP's for completeness. If it was determined that the resident would not return to baseline the LPN or the RN would complete a reassessment of the resident for change of condition, direct the service plan to be updated or update it and assign services if any related to the change of condition.

Record review of R1's face sheet, dated 09/04/2024, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] ([redacted]).

Record review of R1's Master Assessment, dated [redacted]/2024, showed it was their pre-admission assessment. Under the section titled, "cognitive capabilities", showed R1 had a diagnosis of [redacted] and [redacted] that indicated their condition that would affect the resident's orientation in the last six months. R1 was oriented to person, place, time, situation, and did not display any behaviors or exit seeking, wandering, or elopement risk. There was no assistance needed to support R1 as they did not wander. R1 was independent with their call system operation. R1 did not have any conditions that would impact their ability to communicate and was able to communicate and make their needs known. R1 did not require any safety checks.

Record review of R1's Master Assessment, dated 08/16/2024, was a 90-day assessment and the last assessment completed for R1. Under the section titled, "cognitive capabilities", showed R1 was oriented to person, place, time, and situation. R1 did not have any indication conditions listed that would affect the resident's orientation within the last six months. R1 did not wander, exit seek, experience any behaviors, or was not at risk for an elopement that was identified in the last six months. R1 did not required any assistance related to their cognition status. R1 was oriented to person, place, time, and situation. Under the section titled, "functional capabilities", showed R1 was independent with ambulation and independent with coming to the meals in the dining room. Under the section titled, "psychosocial capabilities", showed R1 was able to communicate and make needs known and had no conditions that would impact their capability to communicate.

Record review of R1's Service Agreement, dated 05/17/2024, under the section title, "cognition", showed R1 had age-related issues with long-term and short-term memory. R1 was able to make their own medication decisions. R1 was able to make their needs known without difficulty and was able to understand without assistance. There was nothing documented that R1 had a history of wandering or confusion.

Record review of R1's Temporary Service Plan Isolation, dated 08/13/2024, showed R1 was COVID-19 (Corona Virus Disease 2019- a respiratory illness) positive. There was no documentation or instructions that R1 was experiencing confusion or was wandering.

Record review of R1's Temporary Service Plan Isolation, dated 08/28/2024, showed R1 had recent medications discontinued. Staff were to chart on the resident's mood and if any change in behavior.

Record review of R1's progress note, dated 02/25/2024 at 5:35 AM, showed at 1:30 AM R1 was a bit confused about the time and was trying to get themselves ready for the day. The medication technician had to redirect R1 of the time and that it was time to go back to sleep.

Record review of R1's progress note, dated 04/03/2025 at 5:59 AM, showed R1 was found wandering around the second floor of the facility around 12:15 AM. R1 told the medication technician they were trying to find a way to go upstairs. The medication technician had to help R1 back to their room and into bed. At 12:40 AM, R1 was found downstairs with another resident that was trying to help R1 find their way back upstairs. The medication technician helped R1 back upstairs to their room. R1 was unable to tell the medication technician as to why he was downstairs. At 4:00 AM R1 was found again wandering around on the second floor. R1 told the medication technician they did not know what they were doing or where they were going. The medication technician assisted R1 to their room.

Record review of R1's progress note, dated 07/17/2024 at 5:28 AM, showed R1 was found wandering around on the second floor around 5:15 AM. R1 told the medication technician they did not know where they were or where they were going. Medication technician assisted R1 to their room. R1 told the medication technician that they were glad that they (the staff member) knew where to go as they (R1) did not know where to go.

Record review of R1s progress note, dated 07/31/2024 at 12:31 AM, showed R1 was coming in and out of their room and seemed confused. The caregivers had to redirect R1 into their room.

Record review of R1's progress note, dated 08/09/2024 at 2:35 PM, showed that R1 seemed confused and fatigued (extremely tired).

Record review of R1's progress note, dated 08/14/2024 at 5:56 AM, showed R1 was confused as to why they were not feeling well. R1 had tested positive for COVID-19.

Record review of R1's progress note, dated 08/16/2024 at 9:48 PM, showed R1 was found on the second floor with their bed side table. R1 told the medication technician

they were trying to find their room. The medication technician redirected R1 back to their room.

Record review of R1's progress note, dated 08/20/2024 at 2:22 PM, showed R1 was taken off alert related to recent COVID-19 infection.

Record review of R1's progress note, dated 08/22/2024 at 5:57 AM, showed R1 was found wandering the hall at 1:45 AM. R1 was looking for their bathroom and was found with their pants and brief down. The medication technician assisted R1 to their room when R1 told them they were not aware that they had a bathroom in their room.

Record review of R1's progress note, dated 09/01/2024 at 6:48 AM, showed the medication technician had gone to R1's room to administer their night medication and R1 was not in their room. The medication technician looked around the first floor of the facility and was unable to find R1. The medication technician had the caregiver assist in finding R1. The second floor of the facility was searched without locating R1. The caregiver had gone out the side door to the dining room. Once the caregiver was outside they walked to the front of the facility when they found a walker that was near some bushes. R1 was found lying outside in the bushes on the ground. R1 was wet, muddy, and shaking. R1 denied any pain, but expressed they were cold.

Record review of R1's progress note, dated 09/01/2024 at 1:59 PM, showed Staff A, Executive Director, had called the local hospital emergency room to get a current update on R1's status. R1 did not have a plan for discharge from the local hospital at the time of the call.

In an interview on 09/17/2024 at 10:15 AM, Staff B, Registered Nurse, stated Staff A requested Staff B to complete a mental assessment on R1. Staff B stated they were told R1 was becoming more and more confused and having a difficult time finding their room and the dining room that required R1 to be escorted to and from their room to the dining room. Staff B stated they completed the mental assessment on R1 on 08/20/2024 that showed R1 scored at moderate level of brain syndrome severity (a variety of brain disorders that are characterized by delusions, hallucinations, confusion, and memory impairment). Staff B stated that it was recommended that R1 should be moved to the locked memory care unit of the assist living facility for safety related to R1's decline in cognition. Staff B stated Staff A talked with R1's family with the results of the mental assessment for R1. The facility failed to do a change of condition assessment when R1 exhibited confusion and decline in cognition.

Record review of R1's progress notes, dated 02/22/2024 through 09/02/2024, showed there was no documentation that showed the findings of Staff B's mental assessment on R1. There was no documented conversations with R1's family or representative related to the results of the mental assessment and the recommendation to move R1 to the locked memory care unit for safety.

In an interview on 09/17/2024 at 1:49 PM, Staff C, Resident Care Manager (RCM), stated R1 would sleep some nights but then other nights would be awake. Staff C stated R1's room was moved from the second floor to the first floor because he was having a hard time finding the dining room and then hard time finding their room after being in the dining room. Staff C stated at times R1 would experience confusion, but then they would have moments of clarity. Staff C stated they started working at the facility in July 2024 and that R1 experienced these moments of confusion and clarity the entire time they worked at the facility. Staff C stated R1 was cleared of any medical reasons that could have caused R1's confusion.

In an interview on 09/30/2024 at 8:42 AM, Staff D, Medication Technician, stated R1 was very forgetful and needed more care than what was provided in assisted living. They stated R1 was calm but often confused on where they were going. Staff D was asked if they reported their concerns to anyone, they stated they reported their concerns to the Executive Director and the RCM.

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) 11.14.2024 .

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

Bryan Bow — Administrator (or Representative)

10 18 2024 — Date