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

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 License # 2609

Dear Administrator:

This letter addresses Compliance Determination(s) 63279 (Completion Date 07/29/2025) and 58839 (Completion Date 05/22/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/29/2025 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-2450-1, WAC 388-78A-2450-1-a, WAC 388-78A-2450-1-b, WAC 388-78A-2450-2-f-i, WAC 388-78A-2450-2-f

The Department staff who did the on-site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 follow-up on 04/30/2025 and 05/22/2025 of:

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

This document references the following SOD dated: 05/22/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 0 former residents.

The department staff that inspected 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

Statement of Deficiencies	License #: 2809	Compliance Determination # 58639
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 2 of 7	Licensee: Centralia Point Operating Company LLC	05/22/2025

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.

Clinton Fridley — Residential Care Services

06/03/2025 — 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.

Administrator (or Representative) [signature] Date 6-11-25

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure they had sufficient and qualified staff to meet resident needs for 2 of 2 units (memory care unit and assisted living unit) reviewed. This failure resulted in the memory care unit being left unattended during an incident and placed all 51 of 51 residents at risk for unmet care needs and safety issues.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 12/20/2024, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-2450] as stated in the cited deficiencies in the enclosed report. I understand that to maintain an Assisted Living Facility license, the

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

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Administrator (or Representative) | Date

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This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure they had sufficient and qualified staff to meet resident needs for 2 of 2 units (memory care unit and assisted living unit) reviewed. This failure resulted in the memory care unit being left unattended during an incident and placed all 51 of 51 residents at risk for unmet care needs and safety issues.

Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 12/20/2024, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-2450] as stated in the cited deficiencies in the enclosed report. 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." The administrator section showed Staff G, Former Administrator, signed the document on 12/31/2024. Staff G signed the "Plan/Attestation Statement" for all citations cited that read "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 facility] is or will be in compliance with this law and/or regulation on 02/02/2025."

Record review of the facility policy, titled, "Resident Services," undated, showed, "The community seeks to maintain and enhance each resident's independence through the provision of appropriate care and services. The level of services is identified in the community disclosure statement. The minimum service we provide is housing, basic services and assumption of general responsibility for the safety and well-being of the residents." Under the section titled. "Basic Services," showed, "The administrator and all staff will be responsible for monitoring residents…The administrator will schedule sufficient staff to be available to assist residents as needed and to assure that there is staff in each unit should there be different types living accommodations being offered. (i.e. Memory Care or Assisted Care)."

During a records request on 04/30/2025 at 10:06 AM, a staff schedule, actual worked schedule, to include call outs and no shows for February 2025 was requested.

In an interview on 04/30/2025 at 10:06 AM, Staff A, Operations Specialist, and Staff B, Corporate Wellness Director, were asked what optimal staffing was like for day shift, Staff A stated, there was one medication technician and one caregiver in assisted living and one medication technician and two caregivers in the memory care unit. Staff A stated swing shift was the same. Staff A was asked what staffing was like for NOC (night) shift, they stated there was 1 medication technician shared for both units and a caregiver in assisted living unit and one caregiver for the memory care unit. Staff A stated that was what they have been doing for staffing. Staff B stated since the original citation they had been quicker to utilize agency staff to help with shortages while they were hiring. Staff B stated all the caregivers and medication technicians know they can't leave memory care unattended. Staff B was asked to provide any documents that pertain to the plan of correction, they stated they needed to call the director of operations. Staff A and B were asked if the facility was fully staffed now, they stated yes, with the use of agency.

In an interview on 04/30/2025 at 10:29 AM, Staff C, Medication Technician (Med Tech), was asked if they felt staffing had improved since last November, they stated "no, we have gotten more residents". Staff C was asked if they see agency staff coming in to help, they stated, "yes but sometimes we cant get anyone to come in because it was short notice." Staff C was asked if there was a problem with staffing in memory care, they stated, "yes on all shifts, but more on NOC."

Record review of the facility's February 2025 schedule, dated 04/30/2025, showed the following for NOC shift 10PM-6AM:
02/03/2025- 03/01/2025- 1 Med tech and 1 MC (Memory Care) Caregiver.

In an interview on 04/30/2025 at 11:06AM, Staff A was asked again if the schedule provided was the actual worked schedule, they stated it was.

In an interview on 04/30/2025 at 11:27 AM, Staff B stated they also had a NOC shift housekeeper (Staff D) who in case of an emergency could float around and help if the Med Tech was pulled to the other unit to help the caregiver. Staff B was asked if Staff D had a CNA (Certified Nursing Assistant) or other appropriate credential to provide care to residents, they stated they would have to check with (HR) Human Resources.

Records were requested on 05/02/2025 for the housekeepers schedule from February to current was requested.

Record review of a schedule provided, undated, showed an unspecified time period of one week for two housekeepers. The first housekeeper listed was scheduled to work 6am-2pm Monday through Friday. The second housekeeper listed was scheduled to work 10pm-6am Monday through Thursday and 10am-6pm on Friday. There were no housekeepers scheduled after 6pm on Friday until 6am on Monday.

Records were requested on 05/02/2025 for an actual worked staff schedule to include call outs and no shows from February 2025 to current for housekeepers was requested for the second time and not provided.

In an interview on 04/30/2025 at 11:39AM, Staff B stated Staff D did not have a certificate that would make them a caregiver. Staff B stated they were a straight housekeeper. Staff B was asked if Staff D was CPR (Cardiopulmonary Resuscitation) certified, they stated they didn’t know and were under the impression that because they were a housekeeper that they didn’t need to be certified.

In an interview on 04/30/2025 at 11:50AM, Staff C, Medication Technician, stated there were residents in memory care who were two person assist, there were two people needed to change the residents brief at night. Staff C was asked what staff did when they needed to change the residents brief, they stated the facility hired a housekeeper. That housekeeper would go to the assisted living unit while the med tech went to memory care to assist the caregiver in changing the brief.

In an interview on 04/30/2025 at 12:30PM, Staff E, Medication Technician, stated there were two residents at night that could be rolled when they need a brief change, but if the caregiver was having a hard time and needed a second person, they would call the med tech from assisted living to come help. Staff E was asked if they recently had training related to staffing, they stated they did. Staff E stated they were not allowed to leave memory care unattended and there should always be someone in the unit.

In an interview on 04/30/2025 at 1:11PM, Staff B stated they found an outline of a care

staff meeting that happened in January. Staff B stated they could not find a roster of staff that was in attendance. Staff B stated the outline stated there must be a staff member in memory care at all times. Staff B stated they thought it was just one sentence. Staff B stated more recently they hired agency staff. Staff B was asked what was done for the plan of correction, they stated they don't know. They stated it doesn't mean one wasn't done, but they were unable to find one on the former administrators computer. Staff B stated they were going to call the director of operations. Staff B was shown the February schedule and asked how many staff were scheduled for NOC shift on 02/03/2025, they stated they wanted to look at another schedule because they didn't know if the schedule they were looking at was an actual worked schedule. Staff B was asked to call Staff A to come down to the conference room.

In an interview on 04/30/2025 at 1:24PM, Staff A was asked if they could confirm that the schedule in question was the actual worked schedule, they stated yes. Staff A was asked how many staff were scheduled for NOC shift on 02/03/2025, they stated they were seeing only two. Staff A was asked what would happen if there was an emergency on one of the units during that time, Staff A stated they cant answer that.

In a joint interview on 04/30/2025 at 2:13 PM, Staff B stated they spoke with the director of operations and they do not have a plan of correction. Staff B stated they were not able to find it on the former executive directors computer. Staff A stated they had a housekeeper who was their "universal employee." Staff A stated that in the event that the medication technician needed to go to the caregiver or vice versa, the universal employee was used as the person on the floor until they returned. Staff B stated the housekeeper in February was Staff F but now there was a new one. Staff A was asked if the housekeepers were CPR certified and credentialed to be a caregiver, they stated no. Staff A was asked what someone who was not credentialed or CPR certified to do in an emergency, they stated they would contact the person who was certified. Staff B was asked if having only one person in memory care scheduled to work and only one person in assisted living, if an emergency could pull one staff away from their unit, leaving a unit unattended, Staff B stated they didn't feel comfortable speaking about the schedule from February.

In an interview on 04/30/2025 at 4:27 PM, Collateral Contact 1 (CC1) stated the facility hired a housekeeper to be a third person on NOC shift because there wasn't enough money in the budget for a caregiver. CC1 was asked if they were aware of any incidents that occurred that left one of the units unattended, they stated there was. There was an incident where the Med tech had to call the caregiver to help them upstairs. CC1 stated it was just two staff on shift. A resident had a fall on back to back nights and both times memory care was left unattended because there was no housekeeper on shift. CC1 was asked who the resident was, they stated Resident 2 (R2).

Record review of R2's face sheet, dated 05/21/2025, showed that R2 was admitted to the facility on [redacted]/2025.

Record review of R2's incident report, dated 04/21/2025 at 4:15 AM (NOC shift), showed R2 had a fall with injury. Under the section, "What did you do? Describe all the

assistance given," showed, staff were able to get him off the floor. Med tech had the CNA (Certified Nursing Assistant) come up and help get R2 off the toilet. Med tech and caregiver helped him walk back to their bed and get R2 into bed." Under "comments," showed Care staff found resident on the floor and notified Med Tech. Med tech and caregiver helped resident off the floor and to the bathroom. R2 was a high fall risk.

Record review of the April 2025 working schedule, dated 05/01/2025, showed:
04/20/2025 NOC (night) shift 10pm-6am- 1 Med Tech and 1 Memory Care Caregiver were scheduled, no other staff were scheduled to work.

Record review of R2's incident report, dated 04/22/2025 at 1:53AM, showed R2 had an unwitnessed fall. Under the section, "What did you do? Describe all the assistance given," showed, "The med tech had gone into check on R2 and they were seen lying on the floor. The CNA had come up and helped to get R2 up but they were unable to. R2 was clammy to the touch and 911 was called. R2 was given glucose gel due to having a blood sugar of 40."

Record review of the April 2025 working schedule, dated 05/01/2025, showed:
04/21/2025 NOC (night) shift 10pm-6am- 1 Med Tech and 1 Memory Care Caregiver were scheduled, and no other staff were scheduled.

Review of Department Records showed that a report was made by the facility on 04/16/2025 at 2:50PM notifying the Department that Resident 1 (R1) experienced a fall with injury on 04/12/2025 at 2:48AM.

Record review of R1's face sheet, dated 05/21/2025, showed that R1 was admitted to the facility on [redacted]/2024.

Record review of R1's incident report, dated 04/12/2025 at 2:48 AM (NOC shift), showed R1 had a fall and used their watch alarm to call for help. R1 was found on the bathroom floor with their head resting on the lip of the shower. R1 stated that their back and head hurt. Staff responded and called 911. R1 returned to community later that day but was complaining of pain and to no relief with medication was taken back to the hospital where imaging revealed a fracture to T-12 vertebrae. R1 was now on comfort care awaiting hospice.

Record review of the April 2025 working schedule, dated 05/01/2025, showed:
04/11/2025 NOC (night) shift 10pm-6am- 1 Med Tech and 1 Memory Care Caregiver were scheduled and no other staff were scheduled.

In an interview on 05/02/2025 at 2:56PM, Collateral Contact 2 (CC2), CC2 stated NOC shift was short staffed. They hired a housekeeper to be a third person in the building but lately the NOC shift housekeeper was being pulled to work day shifts when there wasn't one for the day shift. There was an incident that happened where a resident had

Statement of Deficiencies	License #: 2609	Compliance Determination # 58839
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 7 of 7	Licensee: Centralia Point Operating Company LLC	05/22/2025

fallen in assisted living and the other person on shift had to go help. The resident was found and their blood sugar was low and they had to call 911. CC2 stated they don't feel comfortable having a housekeeper to watch the units. CC2 stated they should have credentials. CC2 stated the memory care unit had been very active lately and it was unsafe to leave the residents without a quallfied caregiver. CC2 stated that there were "residents who were two person assist but on paper it stated they were a one person but they fight us 90% of the time so they were a two person assist." CC2 stated there was a resident in memory care who had become combative recently at shift change. The resident busted out the window in their room and was swinging their cane around everywhere. They had cuts on their arms and 911 was called and the ambulance took them to the hospital. CC2 stated the resident comes out of their room randomly, gets angry and tells us to open the door. If there was just two of us there and this happened it would have been "very scary".

This is an uncorrected deficiency previously cited on 12/20/2024.

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) ~~7-14-2025~~ 7-6-2025

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

Administrator (or Representative) [signature] Date 6-10-2025

fallen in assisted living and the other person on shift had to go help. The resident was found and their blood sugar was low and they had to call 911. CC2 stated they don't feel comfortable having a housekeeper to watch the units. CC2 stated they should have credentials. CC2 stated the memory care unit had been very active lately and it was unsafe to leave the residents without a qualified caregiver. CC2 stated that there were "residents who were two person assist but on paper it stated they were a one person but they fight us 90% of the time so they were a two person assist." CC2 stated there was a resident in memory care who had become combative recently at shift change. The resident busted out the window in their room and was swinging their cane around everywhere. They had cuts on their arms and 911 was called and the ambulance took them to the hospital. CC2 stated the resident comes out of their room randomly, gets angry and tells us to open the door. If there was just two of us there and this happened it would have been "very scary".

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Plan/Attestation Statement

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

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Centralia Point Assisted Living and Memory Care
License/Cert.#: 2609
Compliance Determination #: 50310
Investigator: Pamela Horlick
Investigation Date(s): 11/15/2024 through 12/20/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 154780
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Resident/Patient/Client Neglect: Report of staff member leaving memory care unit unattended.
2. Quality of Care/Treatment: Report of staff not using personal protective equipment when providing care to residents.

Investigation Methods:

Sample:	Total residents: 50 Resident sample size: 7 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies Care plans Progress notes investigation incident log Staff working schedule

Investigation Summary:

1. Resident/Patient/Client Neglect: Facility failed to ensure they had sufficient and

qualified staff to meet resident needs for 2 of 2 units (memory care unit and assisted living unit). Failed practice identified.
2. Quality of Care/Treatment: Facility staff interviewed and facility conducted investigation into allegations of staff not wearing PPE when providing care to residents. Unable to substantiate failed practice.

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
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Statement of Deficiencies	License #: 2609	Compliance Determination # 50310
Plan of Correction	Centralia Point Assisted Living and Memory Care	Completion Date
Page 1 of 4	Licensee: Centralia Point Operating Company LLC	12/20/2024

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 11/15/2024 and 12/19/2024 of:

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

This document references the following complaint number(s): 152296, 154780

The following sample was selected for review during the unannounced on-site visit: 7 of 50 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.

Jody Just — 12/24/2024
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.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
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Residential Care Services _____ Date _____

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Bryce Bown
Administrator (or Representative)

12.31.2024
Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

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This requirement was not met as evidenced by:

Based on interviews, and record reviews, the facility failed to ensure they had sufficient and qualified staff to meet resident needs for 2 of 2 units (memory care unit and assisted living unit) reviewed. This failure resulted in memory care unit being left unattended during an incident and placed all 50 of 50 residents at risk for unmet care needs and safety issues.

Findings included ...

In an interview on 12/20/2024 at 6:21 PM, Staff C, 2nd floor ALF (Assisted Living Facility) Medication technician was asked how many residents reside in the memory care unit, they stated they were in rooms 1-21. Staff C was asked if a resident was documented as "Max" assist, does that mean that they require 2 people to provide care including toileting, they stated yes. Staff C stated many of them are incontinent of bowel and bladder and require a lot of care.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," showed 15 residents residing in the memory care unit. Of those 15 residents, 4 require maximum assistance and 4 require Moderate assistance with ADL's (Activities of Daily Living). Of those 15 residents in memory care, 11 are documented to have "dementia/Alzheimer's/cognitive impairment." And 5 are documented to have "Exit seeking/wandering behaviors."

Record review of the facility document titled, "Assisted Living Facility Resident

Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

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Findings included …

In an interview on 12/20/2024 at 6:21 PM, Staff C, 2nd floor ALF (Assisted Living Facility) Medication technician was asked how many residents reside in the memory care unit, they stated they were in rooms 1-21. Staff C was asked if a resident was documented as “Max” assist, does that mean that they require 2 people to provide care including toileting, they stated yes. Staff C stated many of them are incontinent of bowel and bladder and require a lot of care.

Record review of the facility document titled, “Assisted Living Facility Resident Characteristic Roster and Sample Selection,” showed 15 residents residing in the memory care unit. Of those 15 residents, 4 require maximum assistance and 4 require Moderate assistance with ADL’s (Activities of Daily Living). Of those 15 residents in memory care, 11 are documented to have “dementia/Alzheimer’s/cognitive impairment.” And 5 are documented to have “Exit seeking/wandering behaviors.”

Record review of the facility document titled, “Assisted Living Facility Resident

Characteristic Roster and Sample Selection," showed 35 residents reside in the Assisted living unit. Of those 35 residents, 4 require Maximum assist with ADL's (Activities of Daily Living).

Record review of the facility policy, titled, "Resident Services," undated, showed, "The community seeks to maintain and enhance each resident's independence through the provision of appropriate care and services. The level of services is identified in the community disclosure statement. The minimum service we provide is housing, basic services and assumption of general responsibility for the safety and well-being of the residents." Under the section titled. "Basic Services," showed, "The administrator and all staff will be responsible for monitoring residents…The administrator will schedule sufficient staff to be available to assist residents as needed and to assure that there is staff in each unit should there be different types living accommodations being offered. (ie Memory Care or Assisted Care)."

Record review of R1's face sheet, dated 12/13/2024, showed that R1 was admitted to the facility on [redacted]/2024.

Review of the Resident Incident/Accident Log from 10/16/2024 to 11/14/2024 showed on 11/08/2024 at 11:50 PM R1 had a witnessed fall with injury in their bedroom in the assisted living unit.

Record review of facility document, titled, "Resident Incident Report," dated 11/08/2024, showed on 11/08/2024 at 11:50 PM, R1 had a witnessed fall with injury in their bedroom. The report showed, "I looked over resident to see where she was bleeding from and what hurt. CG [caregiver] got her a pillow and blanket. We also covered the spot where she was bleeding from to help stop the blood." Diagram of where R1's injury's were sustained showed a red "X" on the right temple, left side of face, left shoulder, and left knee of R1.

Record review of the November 2024 working schedule showed on 11/08/2024, Staff B, Memory Care unit Caregiver, and Staff C, were scheduled to work that night from 10 PM-6:00 AM.

In an interview on 12/19/2024 at 2:35 PM, Staff A, Executive Director, was asked if memory care should ever be left unattended, they stated, never.

In an interview on 11/19/2024 at 12:47 PM, Staff B, was asked if they would ever leave residents unattended in memory care, they stated, no, but [they] work NOC (night) shift and there had been times they had to go upstairs to Assisted Living unit when there had been an incident to go up and assist. Staff B stated we are not supposed to leave memory care but when there were just two of staff they didn't have a choice. Staff B stated, last week R1 was trying to go to the bathroom, they walked in the room and saw R1 fall. Staff B stated they had to call Staff C, medication technician, to come help. Staff B was asked if the memory care unit was left unattended, they stated, yes it was. Staff

B was asked if Staff A, Executive Director, was aware of the incident, Staff B stated yes, we were to call them when there was an incident. Staff B stated, two of us on night shift was not enough, some of these falls were preventable.

In an interview on 12/09/2024 at 4:11 PM, Staff C, was asked they were aware of a fall R1 had on 11/08/2024, they stated they remembered it. Staff C stated R1 called to use the bathroom, Staff C asked Staff B to go attend to R1. Staff C stated Staff B called them to come help. Staff C stated they ran up to the room and applied pressure to R1's head. Staff C was asked if there was any other staff in the building at that time, they stated no. Staff C was asked if memory care was left unattended, they stated, yes. Staff C was asked how long memory care was left unattended, they stated, maybe 10 minutes. Staff C stated call lights were always going off and people were waiting, we need more staffing.

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) 02/02/2025

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

Bryan Baum
Administrator (or Representative)

12.29.2024
Date

B was asked if Staff A, Executive Director, was aware of the incident, Staff B stated yes, we were to call them when there was an incident. Staff B stated, two of us on night shift was not enough, some of these falls were preventable.

In an interview on 12/09/2024 at 4:11 PM, Staff C, was asked they were aware of a fall R1 had on 11/08/2024, they stated they remembered it. Staff C stated R1 called to use the bathroom, Staff C asked Staff B to go attend to R1. Staff C stated Staff B called them to come help. Staff C stated they ran up to the room and applied pressure to R1's head. Staff C was asked if there was any other staff in the building at that time, they stated no. Staff C was asked if memory care was left unattended, they stated, yes. Staff C was asked how long memory care was left unattended, they stated, maybe 10 minutes. Staff C stated call lights were always going off and people were waiting, we need more staffing.

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

_____ _____

Administrator (or Representative) Date