STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Community Pride Ritzville LLC

Community Pride Ritzville LLC
PO Box 59
Saint John, WA 99171

RE: Community Pride Ritzville LLC License # 2631

Dear Administrator:

This letter addresses Compliance Determination(s) 73236 (Completion Date 07/11/2023) and 22704 (Completion Date 05/19/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/11/2023 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-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3, WAC 388-78A-2290-3-e, WAC 388-78A-2350-6-a, WAC 388-78A-2350-6, WAC 388-78A-2350-7-b, WAC 388-78A-3100-1, WAC 388-78A-3100-2, WAC 388-78A-3100, WAC 388-78A-2484, WAC 388-78A-2484-1, WAC 388-78A-2484-2

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor
Veronica Jackson, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

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

This document was prepared by Residential Care Services for the Locator website.

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 04/24/2023 and 04/27/2023 of:

Community Pride Ritzville LLC
406 S Cascade St
Ritzville, WA 99169

This document references the following complaint numbers: 79709.

The following sample was selected for review during the unannounced on-site visit: 6 of 16 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Joy Pipgras, LTC Surveyor
Janet Quirk, Long Term Care Surveyor
Veronica Jackson, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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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.

Residential Care Services — 02/19/2026 (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

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 interview and record review, the facility failed to ensure that medications were renewed and available for administration for 2 of 6 residents (Residents 1 and 3). This failure resulted in residents not receiving their medications as prescribed.

Findings included...

<Resident 1>

Review of Resident 1's physician's orders dated 01/31/2022 showed that the resident was diagnosed with [redacted], and [redacted].

Review of Resident 1's negotiated services agreement (NSA), dated 08/01/2022, showed that the resident was totally dependent upon facility staff to assist with medication administration, refills, and renewal.

Review of Resident 1's February 2023 medication administration record (MAR) showed that the resident was prescribed magnesium oxide twice per day on 04/26/2021. The

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MAR showed documentation that Resident 1 did not receive magnesium oxide in February, due to "waiting for refill".

Review of Resident 1's physicians orders dated 01/31/2022 showed they were prescribed oyster shell 500-Vitamin D3 200 tablets (a supplement to treat low calcium levels), on 04/26/2021.

Review of Resident 1's prescription order dated 03/13/2022 showed that they were prescribed Senexon (a medication to treat constipation).

Review of Resident 1's March 2023 MAR showed the resident did not receive either oyster shell/Vitamin D3 tablets or Senexon tablets in March 2023. Review of Resident 1's April 2023 MAR showed it did not include the two medications.

In an email received on 05/16/2023 at 5:17 pm, Staff F, Regional Administrator, stated that the oyster shell/Vitamin D3 and Senexon tablets were not transcribed onto the April 2023 MAR.

<Resident 3>

Review of Resident 3's NSA's showed that Resident 3 was able to self-administer medications with assistance from caregivers.

Review of Resident 3's undated medical records showed they had a history of a cerebral infarction (stroke, a condition that disrupts blood flow to the brain), and ongoing constipation.

Review of Resident 3's undated medical record showed a physician's order, dated 01/05/2023, for aspirin, 325 milligrams (mg) (medication prescribed for blood flow) once daily and senna, 8.6 mg (medication to treat constipation) once daily.

Review of Resident 3's February 2023, March 2023, and April 2023 MARs showed documentation that Resident 3 did not receive aspirin from 02/28/2023 to 04/25/2023, (58 days) or senna from 04/02/2023 to 04/25/2023, (25 days). Both medications were documented as "waiting for refill".

In an interview on 04/26/2023 at 11:11 AM, Staff A, Assistant Manager, confirmed Resident 3 had not received their aspirin since 02/28/2023 or senna since 04/02/2023.

In an interview on 04/26/2023 at 11:11 AM, Staff A confirmed they hadn't contacted Resident 1 or 3's providers or representatives about the missed medications.

This document was prepared by Residential Care Services for the Locator website.

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, Community Pride Ritzville LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Administrator (or Representative) Date

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(e) Other information determined necessary by the assisted living facility.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a written plan outlining the details for family assistance with medication for 1 of 6 residents (Resident 5). This failed practice resulted in the resident not receiving a medication for 28 days.

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Findings included...

Review of Resident 5's negotiated service agreement (NSA) dated 03/01/2023 showed that the resident was dependent on facility staff for medication assistance. The NSA did not include a family assistance plan or a plan for the facility to obtain medications in the event that the family could not assist.

Review of a prescription order showed that Resident 5 was prescribed betamethasone valerate .1% lotion (a topical medication used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) on 03/06/2020. The prescription showed that the lotion was to be massaged into the scalp once daily for one week and then applied three times per week for maintenance.

Review of Resident 5's medication administration record (MAR) for February 2023 showed documentation that the facility was waiting for family to refill the resident's betamethasone valerate lotion from 02/01/2023 to 02/28/2023.

In an interview on 04/27/2023 at 2:42 PM, Staff A, Assistant Manager, stated the resident's family or Staff A picks up Resident 5's medications when refilled. Staff A stated they did not have a family plan and were not aware they needed to develop a plan for family to obtain medications.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2350 Coordination of health care services.

(6) When authorizations to release health care information are not obtained, or when an external health care provider is unresponsive to the assisted living facility's efforts to coordinate services, the assisted living facility must:

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(a) Document the assisted living facility's actions to coordinate services;

(7) When coordinating care or services, the assisted living facility must:

(b) Respond appropriately when there are observable or reported changes in the resident's physical, mental, or emotional functioning.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate dental care and treatment for 1 of 6 residents (Resident 3). This failure resulted in unmet dental needs.

Findings included...

Record review of a medical visit summary, dated 01/09/2023, showed a physician's order for Resident 3 to see a dentist for a loose tooth.

Review of the facility's undated disclosure of services showed the facility would help the resident arrange health care appointments, to include transportation, and assisted with coordination of services.

Record review of a medical visit summary, dated 01/18/2023, showed a physician's order stating, "patient needs transport to dentist due to dental issues".

Record review of an email dated 02/15/2023, between Staff F, Regional Administrator, and Staff A, Assistant Manager, showed that Resident 3 had not received dental care.

In an interview on 04/24/2023 at 11:27 AM, Resident 3 stated that they had a loose tooth that was bothering them and wanted to see the dentist. During an observation at that same time the resident demonstrated they had a tooth hanging from their gum that was darker in color than the other teeth.

Record review of Resident 3's medical chart showed no further documentation of any attempts to coordinate dental care with transportation between 02/15/2023 and 04/23/2023.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to secure hazardous supplies. This failure placed residents at risk of harm due to access to unsafe chemicals and tools.

Findings included...

During the environmental tour of the facility on 04/24/2023 at 11:40 AM, with Staff A, Assistant Manager, the following was observed:

- Maintenance cart containing three boxcutters, a pair of scissors, a box of razor blades, and lubricating three in one oil on the first-floor hallway.
- Unlocked maintenance shed located next to the facility which contained 10 bottles of Weed Stop for Lawns (a chemical weed killer), rope, various paints and stains, lubricants, Clorox Bleach Foamer (a chemical cleaning agent), Lime Away (a chemical to remove lime, calcium, and rust stains), motor oil, wasp, and hornet killer, WD 40 (a lubricant), and a large hedge trimmer.
- Two bottles of Tide detergent on an open shelf in the resident's laundry room.
- Broken lock on the door between the east wing bathroom and the sauna tub room that was used for storage. A bottle of isopropyl alcohol was observed in the tub room.

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In an interview on 04/24/2023 at 4:10 PM, Staff F, Regional Administrator, stated that the facility was waiting for permission from Construction Review Services so they could re-purpose the sauna tub room.

Observation on 04/25/2023 at 9:30 AM, showed the maintenance cart had not been moved.

Observation on 04/25/2023 at 9:37 AM showed the maintenance shed door was closed but not locked.

In an interview on 04/25/2023 at 4:26 PM, Staff F stated that the maintenance shed should always be locked.

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 2 of 5 staff (Staff A and D) had received a second Tuberculosis (TB) test, one to three weeks after the first test. This failure placed all residents at risk of exposure to TB infection, (a communicable disease).

Findings included...

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Review of Staff A's personnel file showed they were the Assistant Manager and had a hire date of 02/18/2022. Staff A's personnel file showed they had a first TB test on 02/19/2023 but did not contain documentation of a second TB test.

Review of Staff D's personnel file showed they were a Cook and had a hire date of 01/25/2023. Staff D's personnel file showed they had a first TB test on 01/26/2023 but did not contain documentation of a second TB test.

In an interview on 04/27/2023 at 12:12 PM, Staff A stated they did not have second TB test results for themself or Staff D.

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