STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Community Pride Sunnyside LLC
Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

RE: Community Pride Sunnyside LLC License # 2632

Dear Administrator:

This letter addresses Compliance Determination(s) 40755 (Completion Date 05/06/2024) and 37489 (Completion Date 03/11/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/06/2024 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-2210-1-b, WAC 388-78A-2210-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2632	Compliance Determination # 37489
Plan of Correction	Community Pride Sunnyside LLC	Completion Date
Page 1 of 4	Licensee: Community Pride Sunnyside LLC	03/11/2024

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 follow-up on 03/04/2024 and 03/04/2024 of:
Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

This document references the following SOD dated: 03/11/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Felicia Cantu, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

03/20/2024
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

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 03/04/2024 and 03/04/2024 of:

Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

This document references the following SOD dated: 03/11/2024

The following sample was selected for review during the unannounced on-site visit: 2 of 8 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Felicia Cantu, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
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Union Gap, WA 98903

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 _____

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.

Erin Addison
Administrator (or Representative)

3/26/2024
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(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 interview and record review, the Assisted Living Facility (ALF) failed to implement a safe medication system to ensure residents who required assistance with administration of their medication received medications as prescribed for 2 of 2 residents (Resident 7, 8). These failures resulted in two residents' medications not being documented as given and placed the residents at risk of untreated medical conditions.

Findings included...

Record review of the "Department of Social and Health Services" document, dated 01/01/2024, 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 [WAC 388-78A-2210] 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 A, Executive Director, signed the document on 01/25/2024. Staff A 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 02/25/2024."

Review of the facility's policy titled, "Procedure for Medication Services," dated 09/27/2004, showed that the facility would document and record current prescribed orders for a resident receiving medication assistance or administration onto the Medication Administration Record (MARs). Additionally, the document showed that the staff were responsible for signing the medication administration record to indicate that the

Administrator (or Representative) Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(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 interview and record review, the Assisted Living Facility (ALF) failed to implement a safe medication system to ensure residents who required assistance with administration of their medication received medications as prescribed for 2 of 2 residents (Resident 7, 8). These failures resulted in two residents' medications not being documented as given and placed the residents at risk of untreated medical conditions.

Findings included…

Record review of the “Department of Social and Health Services” document, dated 01/01/2024, 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 [WAC 388-78A-2210] 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 A, Executive Director, signed the document on 01/25/2024. Staff A 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 02/25/2024.”

Review of the facility’s policy titled, “Procedure for Medication Services,” dated 09/27/2004, showed that the facility would document and record current prescribed orders for a resident receiving medication assistance or administration onto the Medication Administration Record (MARs). Additionally, the document showed that the staff were responsible for signing the medication administration record to indicate that the

medication was given correctly.

Resident 7

Review of Resident 7's assessment dated 07/11/2023, showed that they had diagnoses of [redacted], [redacted] and [redacted]. Additionally, the assessment showed the resident needed staff assistance with taking their medications.

Review of Resident 7's Medication Administration Record (MAR), for the dates of 02/25/2024 - 03/04/2024 showed that eight doses of the resident's prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

On 03/04/2024 at 1:55 PM, Staff A, Registered Nurse, stated that the resident had been out of the facility between the date of [redacted]/2024 and [redacted]/2024 and that the resident's medications had been sent with them. They stated that the MAR should have been marked to show that the resident was out of the facility when medications were to be administered. Additionally, Staff A stated that they audited the MAR twice weekly to ensure medications were given as prescribed. They stated that they should have noticed the missing documentation.

Resident 8

Review of Resident 8's assessment dated 01/10/2024, showed that the resident had diagnoses which included [redacted] and [redacted]. The assessment showed that Resident 8 required staff to assist with their medications.

Review of Resident 8's Negotiated Service Plan (NSA) dated 02/16/2024, showed that the resident required all medications be given to them by the Medication Technician.

Review of Resident 8's MAR for the dates of 02/25/2024 - 03/04/2024, showed that six doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

On 03/04/2024 at 1:55 PM, Staff A stated that the MAR should have been marked to show that the medications were given to Resident 8 as ordered. They stated that they did twice weekly audits of the MAR but had not checked it that week.

This is an uncorrected deficiency previously cited on 01/11/2024 subsection 1 (b).

medication was given correctly.

Resident 7

Review of Resident 7's assessment dated 07/11/2023, showed that they had diagnoses of [redacted] ([redacted]), [redacted] and [redacted]. Additionally, the assessment showed the resident needed staff assistance with taking their medications.

Review of Resident 7's Medication Administration Record (MAR), for the dates of 02/25/2024 - 03/04/2024 showed that eight doses of the resident's prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

On 03/04/2024 at 1:55 PM, Staff A, Registered Nurse, stated that the resident had been out of the facility between the date of [redacted]/2024 and [redacted]/2024 and that the resident's medications had been sent with them. They stated that the MAR should have been marked to show that the resident was out of the facility when medications were to be administered. Additionally, Staff A stated that they audited the MAR twice weekly to ensure medications were given as prescribed. They stated that they should have noticed the missing documentation.

Resident 8

Review of Resident 8's assessment dated 01/10/2024, showed that the resident had diagnoses which included [redacted] and [redacted]. The assessment showed that Resident 8 required staff to assist with their medications.

Review of Resident 8's Negotiated Service Plan (NSA) dated 02/16/2024, showed that the resident required all medications be given to them by the Medication Technician.

Review of Resident 8's MAR for the dates of 02/25/2024 - 03/04/2024, showed that six doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

On 03/04/2024 at 1:55 PM, Staff A stated that the MAR should have been marked to show that the medications were given to Resident 8 as ordered. They stated that they did twice weekly audits of the MAR but had not checked it that week.

This is an uncorrected deficiency previously cited on 01/11/2024 subsection 1 (b).

Statement of Deficiencies	License #: 2632	Compliance Determination # 37489
Plan of Correction	Community Pride Sunnyside LLC	Completion Date
Page 4 of 4	Licensee: Community Pride Sunnyside LLC	03/11/2024

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, Community Pride Sunnyside LLC is or will be in compliance with this law and / or regulation on
(Date) 4|25|2024

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

Erin Addison
Administrator (or Representative)

3|26|2024
Date

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 Sunnyside 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Community Pride Sunnyside LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2632
Intake ID: 107770
Compliance Determination #: 34031
Region/Unit #: RCS Region 1 / Unit G
Investigator: Anna Cairns
Investigation Date(s): 12/11/2023 through 01/11/2024
Complainant Contact Date(s): 01/08/2024

Allegation(s):

1. A named resident had an injury on their lower leg which the nurse was notified of but refused to assess for several days .
2. Unqualified staff gave narcotics and insulin to the residents at the Assisted Living Facility (ALF).
3. A named staff member was directed by the nurse to dress/clean residents' cuts and wounds.

Investigation Methods:

Sample:	Total residents: 9 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Medication administration General facility environment
Interviews:	Identified resident Identified staff Care staff Residents Assistant Manager Family members Licensee Regional Registered Nurse Regional Supervisor
Record Reviews:	Medical records (face sheets, progress notes, assessments, care plans, doctors orders) Medication Administration Records (MARs) Hospital records

Incident investigations
Facility policies
Personnel files
Staff training records
Delegation records
Staff patterns
Resident characteristic roster

Investigation Summary:

1. Observation, interview and record review showed that the named resident sustained a fracture to their left ankle that was not addressed for three days. The resident required hospitalization and returned to the facility with significant wounds requiring ongoing wound care which the ALF failed to provide. The ALF failed to ensure the resident was assessed and monitored for their change of condition, and failed to ensure the ALF did not retain a resident whose needs could not be met at the facility. Additionally, the ALF failed to investigate the incident that resulted in the residents fractured ankle. Failed practice identified under Resident characteristics, 388-78A-2100 Ongoing Assessments, 388-78a-2120 Monitoring Residents' Well Being, and 388-78a-2371 Investigations. See the Statement of deficiencies dated 01/11/2024.
2. Interview and record review showed that he ALF did not ensure staff were properly trained on specific residents' medication administration needs, and failed to ensure a safe medication services system was implemented. Failed practice identified under WACs 388-78a-2210 Medication Services, and 388-78a-2320 Intermittent Nursing Services Systems. See the Statement of deficiencies dated 01/11/2024.
3. Interview and record review showed that no staff were directed to provide wound care above or beyond basic first aid as allowed by the regulations. No failed provider practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Community Pride Sunnyside LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2632
Intake ID: 107757
Compliance Determination #: 34031
Region/Unit #: RCS Region 1 / Unit G
Investigator: Anna Cairns
Investigation Date(s): 12/11/2023 through 01/11/2024
Complainant Contact Date(s):

Allegation(s):
A named resident began to refuse care and medications repeatedly, and eventually left the facility unescorted.

Investigation Methods:

Sample:	Total residents: 9 Resident sample size: 6 Closed records sample size: 0
Observations:	Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Medication administration General facility environment
Interviews:	care staff Residents Family members Assistant Manager Regional Nurse Regional Supervisor Licensee
Record Reviews:	Medical records (face sheets, care plans, assessments, progress notes, doctors orders) Hospital records Incident investigations Facility policies Personnel files Staff training records Staff patterns Resident Characteristic roster

Investigation Summary:

Interviews and record reviews showed the named resident had previously left the facility unattended, and that in October 2023 the resident's known behavior of refusals of food, medication, and medical appointments began to escalate. The behaviors continued and the named resident did not receive necessary medications for their medical needs and their mental health issues. The named resident left the facility when they became upset about a medical appointment they were supposed to have. The facility failed to assess the resident when they refused medications and had increase in known behaviors. The facility failed to investigate the incident leading to the resident leaving the facility and failed to implement interventions for the resident's behaviors. Failed practice identified under WAC 388-78a-2100 Ongoing Assessments and WAC 388-78a-2371 Investigations. See the Statement of Deficiencies dated 01/11/2024.

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
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Community Pride Sunnyside LLC
Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

RE: Community Pride Sunnyside LLC # 2632

Dear Administrator:

This document references the following complaint numbers 107770, 107757.

The Department completed a full inspection of your Assisted Living Facility on 01/11/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Gwin Kaercher, Field Manager
Residential Care Services

Region 1, Unit G
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040 , that is the resident's primary special need.

The Assisted Living Facility (ALF) failed to ensure that staff completed specialized training for developmental disabilities when one or more of the residents at the facility had a developmental disability.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 12/11/2023, 12/12/2023, 12/13/2023, 12/14/2023 and 12/15/2023 of:

Community Pride Sunnyside LLC
908 North Ave
Sunnyside, WA 98944

This document references the following complaint numbers: 107770, 107757.

The following sample was selected for review during the unannounced on-site visit: 6 of 9 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor
Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Gwin Kaercher
Residential Care Services

01/25/2024
Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

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 12/11/2023, 12/12/2023, 12/13/2023, 12/14/2023 and 12/15/2023 of:

Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

This document references the following complaint numbers: 107770, 107757.

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Jessica Clapp, Assisted Living Facility Licensor
Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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 _____

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-2100 Ongoing assessments.

(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 ;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to complete an assessment for residents who had sustained an injury or experienced a change in their condition for 3 of 4 residents (Residents 3, 5, 6). This failure contributed to a delayed treatment for the residents and placed the residents at risk of unmet care needs and decline in chronic medical conditions.

Findings included…

Record review of facility policy titled, “Limited Nursing Services,” undated, showed that the facility was to reassess the resident’s needs when staff noticed a change in the resident's functional ability or health status, and amend the individual's resident plan accordingly.

On 12/11/2023 at 10:19 AM, Staff G, Regional Supervisor, stated that if there is an incident or injury and the nurse was not at the facility to complete an assessment, staff were to notify the resident’s primary care physician (PCP), send the resident to the emergency room (ER) if needed, or set-up a doctor’s appointment.

Resident 3

Review of Resident 3’s 11/07/2023 facility admission assessment showed that the resident was admitted to the ALF on [redacted]/2023. Resident 3 required assistance for all activities of daily living which included transfers, mobility and was at risk of falls.

Review of a facility's communication document showed that on [redacted]/2023 at 4:16 PM Staff G was informed that Resident 3's was transferred to hospital due to their, "red, swollen painful foot."

Review of Resident 3's hospital treatment note dated [redacted]/2023 showed that the resident was admitted to the hospital on [redacted]/2023 with diagnoses of [redacted], [redacted] and [redacted].

Review of Resident 3's hospital post-operative report dated [redacted]/2023 showed that the resident had surgery for a right ankle fracture.

Review of Resident 3's Hospital Discharge Summary dated [redacted]/2023 showed that the resident was discharged back to the ALF with an order for six weeks of antibiotics for their infection and needed to be non-weight bearing (unable to put pressure on the leg) on their right leg.

Review of Resident 3's record showed no assessments were completed by the facility when the resident returned from the hospital on [redacted]/2023 through [redacted]/2023.

On 12/13/2023 at 1:09 PM Staff H, Regional Registered Nurse (RN) was observed to remove dressings and assess Resident 3's right lower leg. Removal of a plastic splint showed red and brown drainage on the gauze squares inside the splint, which indicated dried blood and drainage from the heel area of the resident's foot. As Staff H, RN, removed several layers of gauze wrap from Resident 3's leg, they stated that there was an excessive amount of gauze on the leg and that it was clear that the dressing had not been changed in several days. Removal of the gauze wrap showed that a four inch by four inch gauze square was stuck to the resident's shin by a wide strip of dried red and brown blood and drainage that required repeated saline (cleansing salt water solution) application to remove the gauze. There was a full thickness wound to Resident 3's shin that Staff H, RN, stated was three inches long by one inch wide, with a brown dry outer perimeter, a bright red middle perimeter, and a pale moist center to the wound. Resident 3's foot showed that they had six surgical incisions to the top of the foot, outer ankle, and sole of the foot, with a total of 15 stitches over all. The skin on Resident 3's foot was dry and peeled off in large flaky layers as Staff H, RN, cleansed the area. In cleaning the heel of the foot, a two-inch diameter blister was opened up incidentally. The blister had a white moist outer layer of skin and was bright red underneath. Additionally, a dime sized area of red to purple in color was observed on the back of Resident 3's ankle, which Staff H, RN, then stated was the start of a pressure wound.

On 12/13/2023 at 1:28 PM, Staff J, Caregiver, stated that Resident 3 had a habit of crossing their left lower leg over top of their right leg, which caused the original wound on their shin, and that it had been there since the resident returned from the hospital.

On 12/13/2023 at 3:02 PM, Staff G, stated that assessments were not completed when the resident returned from the hospital to the ALF on [redacted]/2023. Staff G acknowledged

assessments should have been completed for Resident's 3's changes in condition including of surgical wounds, newly identified wounds, infection and changes in weight bearing status.

Resident 6

Review of Resident 6's NSA dated 02/22/2023 showed that they had diagnoses of [redacted], [redacted], and [redacted]. The NSA showed Resident 6 required the use of supplemental [redacted] could walk with their walker with a caregiver nearby and did not need assistance with mobility more than two times per week.

Review of Resident 6's progress notes dated 09/10/2023, showed that they had fallen and got a small cut above their eye and near their ear.

Review of Resident 6's progress notes dated 09/30/2023 showed that staff were changing the resident and found bruising on their buttocks. The note showed that resident 6 had decreased energy, had shakiness and they were weak. Additionally, it took three times for staff to wake them for dinner.

Review of Resident 6's progress notes dated 10/14/2023 showed that the resident almost fell when using the restroom and they hit their head on the toilet.

Review of Resident 6's progress notes dated 11/28/2023 showed that the resident needed help standing and complained of pain.

Review of Resident 6's record showed that between 09/30/2023 – 12/11/2023 there was no documentation of an assessment or action taken for Resident 6's falls, unexplained bruising, breathing problems, pain, or incidents of weakness.

On 12/11/2023 at 12:20 PM, observation showed that Resident 6 was escorted in their wheelchair to the dining room by caregivers. Resident 6's head dropped onto their bowl of food and they knocked their cup of water over on the table. Staff E, Caregiver, stated that Resident 6's had been having these episodes, "every couple of weeks." Resident 6's head continued to drop, hitting the table repeatedly, five times in a row. Resident 6 requested their supplement drink and was handed it to them by the staff. Resident 6 was unable to steady their hand and their drink spilled on their pants and shirt.

On 12/11/2023 at 12:40 PM, Staff E was asked what they do when Resident 6 has these incidents, and they stated that they would let their doctor know. Staff E did not call their doctor after the incident.

On 12/11/2023 at 12:45 PM, observation showed that facility staff did not call the nurse,

doctor, a supervisor or Emergency Medical Services (EMS) for Resident 6. Additionally, Resident 6 continued to drop their head on the table.

On 12/11/2023 at 12:46 PM after being notified by the licensors of Resident 6's condition, Staff G called the facility and directed the staff to check Resident 6's vital signs. Due to an elevated fever, Staff G directed the staff to call EMS.

On 12/11/2023 at 3:24 PM Staff G stated that Resident 6 was admitted to the hospital with a diagnosis of [redacted].

Resident 5

Review of Resident 5's Negotiated Service Agreement dated 09/13/2023, showed they were admitted to the ALF on [redacted]/2023 with diagnoses that included [redacted].

Review of facility Physician's Orders dated 10/01/2023, showed Resident 5 had orders which included Glipizide and Metformin (medications to regulate blood sugars), Olanzapine (medication to treat mental disorders) and Lisinopril (medication to regular blood pressure).

Review of the facility "Behavior Support Plan (BSP)" undated, showed Resident 5 had refused to take their medications for mental disorder, blood pressure and diabetes since 10/06/2023 and that the resident had declined to go to physician and [redacted] appointments.

Review of Resident 5's progress notes dated 10/10/2023 showed that the resident expressed anger toward staff, refused to take their medication, and refused to have their room cleaned.

Review of Resident 5's progress notes dated 10/17/2023 showed that the resident refused to take medications, was agitated toward staff, and went outside to smoke in the middle of the night.

Review of Resident 5's progress notes dated 10/19/2023 showed that the resident refused medications, was agitated, and accused caregivers of, "playing tricks."

Review of Resident 5's MAR for October 2023 showed that Resident 5 started to refuse taking medications on 10/07/2023 which included medications for Schizophrenia, blood pressure and diabetes.

Review of Resident 5's progress notes dated October 2023 showed that the resident refused to take their medications 19 times that month.

Review of Resident 5's progress notes dated 11/17/2023 showed that the resident was going outside every 30 minutes and refused to take their medications.

Review of Resident 5's progress notes dated 11/17/2023 showed that the resident, "was in a bad mood" and broke their television by throwing it.

Review of Resident 5's progress notes dated 11/19/2023 showed that the resident stared at the caregiver and told them, "One day we will go eye to eye."

Review of Resident 5's progress notes dated 11/21/2023 showed that the resident refused medication and yelled at the caregiver. The resident told the caregiver, "You want to know all my secrets, you can't. I will kill everyone not with knives or swords." The notes showed the caregiver notified Staff A, Registered Nurse (RN)/Assistant Manager.

Review of Resident 5's progress notes dated [redacted]/2023 showed that the resident was agitated after Staff A, RN, did not have transportation to an appointment that day. The notes showed that the resident packed their suitcase and left the facility.

Review of Resident 5's MAR for November 2023 showed that the resident refused to take their medication from 11/1/2023 thru 11/21/2023. The MAR showed that the resident left the facility on [redacted]/2023 by their own choice.

Review of Resident 5's progress notes for November 2023 showed that the resident continued to refuse their medications routinely.

Review of Resident 5's records showed that the facility nurse did not complete an assessment when the resident refused their medications and did not complete an assessment that showed the resident's decline in their mental health since admission.

This a recurring deficiency previously cited on 06/27/2023.

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 Sunnyside 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-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to evaluate and take action when changes in condition occurred for 2 of 2 residents (Resident 3, 6). These failures contributed to delayed treatment for both residents and contributed to Resident 3 experiencing pain and hospitalization.

Findings included…

Record review of facility's policy titled, "Limited Nursing Services," undated, showed that the facility was to reassess the resident's needs when staff noticed a change in the resident's functional ability or health status, and amend the individual's resident plan accordingly.

Resident 3

Review of Resident 3's hospital notes dated 11/05/2023 (prior to admission to the facility), showed that the resident had a wound to their right leg and it was pink, with good circulation.

Review of Resident 3's facility assessment dated 11/07/2023, showed that the resident was admitted to the ALF with diagnoses that included [redacted], [redacted] ([redacted]), and [redacted] ([redacted]).

Review of Resident 3's Negotiated Service Agreement (NSA) dated [redacted]/2023, showed that the resident required extensive two-person assistance for transfers, required the use of a wheelchair for mobility, was blind and had brain damage. The NSA showed that the resident required monitoring for skin integrity and that, "Resident has big infected wound on the right leg." The NSA showed the wound required daily cleaning and dressing by a nurse.

Review of Resident 3's Skin Assessment completed by Staff A, Registered Nurse, (RN) /Assistant Manager, dated [redacted]/2023, showed that Resident 3 was admitted with skin conditions including one on their right hand, left hand, left leg, a large bruise on the back and a, "big wound on right leg." Treatment for the wounds included daily cleaning and wound dressing on the right leg. Additionally, the document showed the wounds were clean and without infection.

Review of hospital discharge orders dated [redacted]/2023 showed that Resident 3 was ordered to have home health nursing visits for wound care services to the lower right leg.

Review of Resident 3's progress notes dated 11/16/2023 showed that Staff A, RN cleaned and dressed the wound on the right leg. Additionally, Staff A, RN noted that the wound was, "black in the center."

Review of Resident 3's record showed no documentation of daily wound treatments, evaluations, and actions taken from 11/08/2023 - 11/15/2023 and 11/17/2023 - 11/20/2023.

Review of Resident 3's progress notes dated 11/18/2023, showed that the resident started to have difficulty getting onto their toilet, complained that their right foot hurt and wanted caregivers to stay with them in their room.

Review of Resident 3's progress notes dated 11/19/2023 showed that the resident's right ankle was swollen, bent inward and that the resident was, "in great pain." Additionally, the progress note showed that the resident was not able to stand.

Review of Resident 3's progress notes dated [redacted]/2023 showed that the resident did not sleep well that night and wanted staff to stay with them in the room.

Review of Resident 3's Medication Administration Record (MAR) dated November 2023, showed that the resident had an order for Acetaminophen (an over-the-counter pain reliever) to be administered every four hours as needed. The MAR showed there was no other medication prescribed for pain relief. The MAR did not show any change in pain management order when the resident's pain increased on 11/18/2023.

Review of a facility's communication document showed that on [redacted]/2023 at 4:16 PM, Staff A, RN, informed Staff G, Regional Supervisor, that Resident 3 was transferred to the hospital due to their, "red, swollen painful foot."

Review of Resident 3's hospital treatment note dated [redacted]/2023, showed that the resident was admitted to the hospital on [redacted]/2023 with diagnoses of [redacted], [redacted] and [redacted].

Review of Resident 3's hospital surgeon's notes dated [redacted]/2023, showed, "there is a possibility that [Resident 3] may have a deep infection, which may necessitate further surgical intervention, and may ultimately result in an amputation (a surgical removal of a part of the body)."

Review of Resident 3's hospital post-operative report dated [redacted]/2023, showed that the resident had surgery for their right ankle fracture.

Review of Resident 3's hospital treatment notes dated 11/28/2023, showed that the resident required non-weightbearing to their right leg (unable to put pressure on the leg) for six weeks and daily wound care.

Review of Resident 3's Hospital Discharge Summary dated [redacted]/2023, showed that the resident was discharged back to the ALF with an order for six weeks of antibiotics for their infection and needed to be non-weight bearing on their right leg.

Review of Resident 3's record from 11/30/2023 - 12/11/2023 did not show documentation of daily wound cleaning and dressing done by a nurse and did not show that the resident's wound was monitored.

On 12/11/2023 at 10:19 AM, Staff G stated that if a resident had new or high level of pain, the facility would call emergency services.

On 12/13/2023 at 12:05 PM, Resident 3 stated that they had been left in pain for a couple of days.

On 12/13/2023 at 2:56 PM, Staff G stated that there were no updates to care staff about Resident 3's wound upon their return from the hospital. Staff G stated that there was no direction for staff to care for the resident or their weight-bearing status. Staff G stated that the facility did not implement a plan for monitoring the wound for Resident 3, upon their return from the hospital.

On 12/15/2023 at 12:04 PM, Staff G, stated that Staff A, RN was on vacation as of 12/10/2023 would not be back from vacation until 01/05/2024.

On 12/18/2023 at 3:13 PM, Staff K, Caregiver, stated that they worked the night shift on 11/18/2023 and the previous shift reported to them that Resident 3 had pain. Staff K observed that the resident had a swollen leg and they notified Staff A, RN. They stated they did not know if Staff A, RN came to the facility in the morning. They stated they did not call emergency services to evaluate Resident 3.

On 12/19/2023 at 3:15 PM, Staff D, Caregiver, stated that they worked the night shift on

11/18/2023 and observed Resident 3's leg injury. Staff D stated that the resident was in such pain that they had to be changed in their bed rather than getting up to use the toilet. They stated that they took a picture of the leg and sent a text message to Staff A, RN. Staff D stated that they did not receive a response back from Staff A, RN.

On 12/27/2023 at 2:51 PM, Staff G stated that they had concerns about the lack of action from Staff A, RN when they were notified of the resident's injury on [redacted]/2023. Staff G acknowledged Resident 3 had a delay in medical treatment.

Resident 6

Review of Resident 6's NSA dated 02/22/2023 showed that they had diagnoses of [redacted], and a [redacted]. The NSA also showed that Resident 6 required the use of supplemental [redacted]. In addition, Resident 6's NSA showed that they could walk with their walker, was alert and oriented and able to communicate their needs.

On [redacted]/2023 at 12:20 PM, observation showed that Resident 6 was escorted in their wheelchair to the dining room by caregivers. Resident 6's head dropped onto their bowl of food, and they knocked their cup of water over on the table. Staff E, Caregiver, stated that Resident 6's had been having these episodes, "every couple of weeks." Resident 6's head continued to drop, hitting the table repeatedly, five times in a row. Resident 6 requested their supplement drink and was handed it to them by the staff. Resident 6 was unable to steady their hand and their drink spilled on their pants and shirt.

On [redacted]/2023 at 12:40 PM Staff E, Caregiver, was asked what they do when Resident 6 has these incidents, and they stated that they would let their doctor know. Staff E did not call their doctor after the incident.

On [redacted]/2023 at 12:45 PM, observation showed that facility staff did not call the nurse, doctor, a supervisor or Emergency Medical Services (EMS) for Resident 6. Additionally, Resident 6 continued to drop their head on the table.

On [redacted]/2023 at 12:46 PM After being notified by the licensors, Staff G called the facility and directed the staff to check Resident 6's vital signs. Due to an elevated fever, Staff G directed the staff to call EMS.

On [redacted]/2023 at 3:24 PM, Staff G stated that Resident 6 was admitted to the hospital with a diagnosis of [redacted], and [redacted].

On 12/15/2023 at 12:04 PM, Staff G, stated that Staff A, RN was on vacation as of 12/10/2023 would not be back from vacation until 01/05/2024.

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, Community Pride Sunnyside 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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(ii) The resident's full assessments;

(iii) On-going assessments of the resident;

(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to develop a Negotiated Service Agreement (NSA) that addressed the resident's needs and interventions for risks which included diagnoses, activities of daily living, and intermittent

nursing services for 6 of 6 residents (Residents 1, 2, 3, 4, 5, 6). This failure placed the residents at risk of unmet needs and complications from their chronic medical conditions.

Findings included…

Resident 1

Review of Resident 1's 03/10/2023 Negotiated Service Agreement (NSA) showed that the resident had diagnoses which included [redacted]. The NSA showed that Resident 1 wore a brace on their left leg and left wrist.

Review of Resident 1's 08/17/2023 Department assessment showed that the resident had a history of diabetes, seizures (involuntary and controlled spasms and movements of the body) and a stroke. The assessment showed that Resident 1 had, "2-3 seizures this year." Additionally, the assessment showed that Resident 1 required routine blood draws every three months to monitor medication levels as well as daily blood sugar testing by the staff (to monitor blood sugar levels related to their diabetes).

Review of Resident 1's 10/10/2023 Physician's Orders showed that the resident was prescribed Clopidogrel (a blood thinner to prevent blood clots which increases risks of unusual bleeding) and Depakote (a medication to control seizures which required routine blood work to monitor therapeutic levels).

Review of Resident 1's October 2023 and November 2023 Medication Administration Records (MARS) showed that the resident had orders for Epinephrine (a hormone medication to treat emergent automatic body systems responses) injections as needed for severe allergic reaction.

On 12/12/2023 at 11:38 AM, Resident 1 was observed walking down the hall independently using their cane. Their left arm hung limply at their side and their left leg drug slightly as they walked. There were no braces observed on the resident's leg or wrist.

Review of Resident 1's NSA did not provide direction on the special care considerations, monitoring needs, and risks associated for the resident's diagnoses of [redacted]. The NSA did not provide the plan to monitor and provide care to the resident for the risks associated with their significant medications, and injections, including who was responsible to administer the medications and blood sugar tests. Additionally, the NSA did not indicate who was responsible to ensure the resident had their supportive braces applied daily.

Resident 2

Review of Resident 2's Physician's Orders dated 10/01/2023, showed that the resident had diagnoses which included [redacted] and [redacted]. The orders showed that Resident 3 was prescribed three medications to regulate their blood sugar.

Review of Resident 2's facility assessment dated 06/14/2023, showed that the resident haddiagnoses of [redacted] and [redacted] ([redacted]). The assessment showed that the resident required blood sugar monitoring and that they were to have medicated creams applied to their skin.

Review of Resident 2's NSA dated 08/25/2023, showed that they had diagnoses of [redacted] and [redacted]. The NSA showed that the resident required blood sugar monitoring and application of lotions to the skin. The NSA did not show direction on how to monitor for risks associated with resident's diagnoses and significant medication, nor did it show who was responsible to administer their blood sugar tests or their creams.

Resident 3

Review of Resident 3's 10/01/2023 orders Physician's Orders showed that they were prescribed Erthyromycin (prescription medication for eye infection), Insulin (a medication to control blood sugar levels) injections, and Prednisolone (an eye drop medication for inflammation of the eye).

During an observation on 12/12/2023 Resident 3 was not present for lunch. Staff E, Caregiver, stated that Resident 3 was at the eye doctor for an appointment.

Review of Resident 3's facility assessment dated 11/07/2023 showed that the resident was blind, had difficulty swallowing food, that they required glucose monitoring and insulin injections administered by staff, and had a stroke. Additionally, it showed that Resident 3 required, "Reminders, cues, and supervision in planning, organizing and performing daily routines."

Review of Resident 3's facility skin assessment dated 11/08/2023 showed that the resident had one small wound on their right hand, one small would on their left hand, a wound on their left leg, a big wound on their right leg, and a big bruise on their back. Additionally, it showed that Resident 3 was admitted with the wounds.

Review of Resident 3's NSA, dated 12/08/2023 showed that the resident had diagnoses that included [redacted], [redacted], [redacted], [redacted] ([redacted]) and [redacted].Additionally, the NSA showed that Resident 3 required daily wound care by a

nurse.

Resident 3's NSA did not provide direction for staff, monitoring needs, and risks associated for the resident's diagnoses of [redacted], [redacted], [redacted], and [redacted]. The NSA did not provide the plan to monitor the resident for the risks associated with the significant medications, eye drops, blood sugar tests and injections for Resident 3. Additionally, the NSA did not indicate what staff were to monitor for or actions to take regarding Resident 3's wound.

Resident 4

On 12/12/2023 at 2:22 PM, Resident 4 was observed walking to their room, with a walker. The walker was far in front of them, they walked slowly and drug their feet with each step. Resident 4 stated that they had trouble walking with their current walker and due to their blindness.

Review of Resident 4's 03/12/2023 facility assessment showed that the resident had diagnoses of [redacted] ([redacted]) and [redacted].

Review of Resident 4's NSA dated 10/20/2023 showed that the resident had diagnoses which included [redacted] and [redacted]. The NSA did not provide information or direction on the risks and safety concerns, special considerations, or what to monitor for related to Resident 4's diagnosis of [redacted].

Resident 5

Review of Resident 5's Physician's Orders dated 10/01/2023, showed that the resident had a diagnosis of [redacted] and [redacted]. The record showed the resident was prescribed Glipizide and Metformin (medications used to regulate blood sugars) and Olanzapine (medication used for mental disorders).

Review of Resident 5's NSA dated 09/13/2023, showed they had a diagnosis of [redacted]. The NSA did not provide staff with direction for monitoring the risks associated with their diagnosis of [redacted] and their significant diabetic medications.

Review of Resident 5's progress notes dated [redacted]/2023 showed that the resident left the facility unescorted on [redacted]/2023 and that they were to be monitored by staff. The NSA did not provide direction to staff of what to do and who to contact should the resident leave the facility unescorted again.

Resident 6

Review of Resident 6's facility assessment dated 03/09/2023 showed that the resident had Glaucoma (eye disease that causes blindness) in both eyes, used supplemental [redacted] for chronic obstructive pulmonary disease (COPD-lung disease that blocks airflow and restricts breathing), and required staff to administer their eye drops.

Review of Resident 6's NSA, dated 02/22/2023 showed that they had diagnoses of [redacted] ([redacted]) [redacted], [redacted], and [redacted]. The NSA showed that the resident was on supplemental [redacted].

Resident 6's 10/01/2023 Physician's Orders showed that the resident was prescribed three eye drops for Glaucoma, three inhaled medications, a blood thinner, and other medications to treat their heart and lung conditions.

Resident 6's NSA did not provide direction for staff, monitoring needs, and risks associated for the resident's diagnoses and significant medications for their [redacted], [redacted], [redacted], and [redacted]. The NSA did not show the plan for who was responsible for providing and assisting with the [redacted], safe storage, and what to do if complications with their supplemental [redacted] occurred.

On 12/11/2023 at 9:31 AM, Staff G, Regional Supervisor stated that the facility's nurse was responsible for residents' pre-admission assessments, full assessments, and ongoing assessments and NSA's.

On 12/12/2023 at 3:30 PM, Staff G stated the NSA's should have had specific services and specify who to contact for the residents.

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 Sunnyside 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-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service

agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide care and services per the Negotiated Service Agreement (NSA) when a resident required wound care by a nurse for 1 of 1 resident (Resident 3). This failure resulted in Resident 3 not receiving care and services as agreed upon in their NSA and contributed to Resident 3's unmet treatment needs and declined condition.

Findings included…

Review of Resident 3's hospital notes dated 11/05/2023 showed that they had a wound on their right lower leg that was, "Fragile/bleeds easily."

Review of Resident 3's 11/07/2023 facility assessment showed that the resident was admitted to the ALF on [redacted]/2023 with diagnoses that included [redacted], and [redacted].

Review of Resident 3's initial NSA dated [redacted]/2023 showed that, "Resident has big infected wound on the right leg: The nurse needs to clean and dress daily." The NSA also showed that, "Resident has local infection of the skin," that required daily dressing changes.

Review of Resident 3's hospital treatment notes showed that the resident was admitted to the hospital on [redacted]/2023 with diagnoses of [redacted], and [redacted] and [redacted].

Review of Resident 3's record did not show documentation that the resident received daily wound care from [redacted]/2023 – [redacted]/2023.

Record review of the hospital's surgeon notes in Resident 3's record, dated [redacted]/2023, showed, "there is a possibility that [Resident 3] may have a deep infection, which may necessitate further surgical intervention, and may ultimately result in an amputation (a surgical removal of a part of the body)."

Review of Resident 3's hospital discharge summary dated [redacted]/2023, showed that the resident was discharged back to the ALF with an order for antibiotic medication for six weeks, to treat the infection in their leg.

On 12/12/2023 at 1:42 PM, Staff G, Regional Supervisor stated that they were unaware of Resident 3's daily wound care indicated on their initial NSA.

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 Sunnyside 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-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(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 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(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 observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure medication orders were followed as prescribed for 2 of 6 residents (Resident 1,3), failed to ensure medications were documented as given for 5 of 6 residents (Residents 1, 2, 3, 5, 6), and failed to ensure medications were only administered to themselves as labeled for 1 of 6 residents (Resident 4). These failures resulted in 5 residents (Residents 1,2 ,3 ,5 ,6) not receiving their medications as ordered and contributed to Resident 1's falls and hospitalizations, and also placed all residents at risk for further complications due to medications not being given as ordered.

Findings included…

Review of the facility's policy titled, "Medication Services" dated 09/27/2004, showed that medication assistance meant, "The resident must be able to put the medication into his or her mouth or apply or instill the medication." Medication administration meant that the medication was administered by a person who is authorized to do so. The facility would document and record current prescribed orders for a resident receiving medication assistance or administration onto the Medication Administration Record (MAR) and that staff were responsible for signing the MARs to indicate medication was given correctly.

Resident 4

On 12/12/2023 at 2:22 PM, Resident 4 was observed walking to their room, with a walker. The walker was far in front of them, they walked slowly and drug their feet with each step. Resident 4 stated that they were mostly blind and had trouble walking.

Review of Resident 4's 03/12/2023 facility assessment showed that the resident had diagnoses of [redacted].

Review of Resident 4's Negotiated Service Agreement (NSA), dated 10/20/2023, showed that the resident had diagnoses which included [redacted]. The NSA also showed that Resident 4 required medication assistance and was able to ask for as-needed medications appropriately.

Review of Resident 4's Physician's Orders dated 10/03/2023 showed that the resident was on Gabapentin routinely for pain related to their multiple sclerosis, as well as Tylenol as needed for pain.

On 12/12/2023 at 12:25 PM, a medication pass observation was made as Staff E, Caregiver, was assisting with Resident 4's medication. Staff E was observed to dispense a tablet of Tylenol 500 mg from an over-the-counter bottle of the medication that they had pulled from the drawer of the medication cart. The bottle of the Tylenol had the name of Resident 6 written on it with a black marker. When asked why the bottle had a different name than Resident 4's name on it, Staff E stated that Resident 4 must have run out of their supply of Tylenol, and that they didn't know what happened since they only worked three days a week. Staff E stated that they did not know why the bottle was labeled with Resident 6's name, and that the bottle was, "house supply."

On 12/12/2023 at 1:45 PM, when asked if they used house supply medications at the ALF or if it was customary to use one resident's medication for another resident, Staff G, Regional Supervisor, stated, "that's not the system, we have systems in place, not sure what is going on." Staff G stated that the ALF was to audit all medication supply every two weeks.

Resident 1

Resident 1's 03/10/2023 NSA showed that Resident 1 had diagnoses which included [redacted]. The NSA showed that Resident 1 required staff to assist with their medication, and that the resident was on antipsychotic (medications to treat mental health and mood disorder) medications.

On 12/11/2023 at 2:30 PM, Resident 1 stated that they had a history of a stroke (damage to the brain due to an interruption of the blood supply) and that staff assisted them with their medications.

Review of Resident 1's progress notes dated 11/15/2023 showed that the resident had an appointment with a neurologist (a doctor specializing in the study of the nervous system), who indicated that the resident was having drug induced tremors because of the Invega injection (antipsychotic medication to treat mood disorders). The neurologist indicated that they would contact the resident's [redacted] doctor about their medication.

Review of Resident 1's progress notes dated 11/18/2023 showed that the resident's [redacted] doctor changed the order for their Invega (to treat mood disorders) from once every 30 days to once every 21 days. The doctor also started Resident 1 on Benztropine (to treat tremors caused by other medication) 1 milligram (mg) orally twice daily, and Buproprion (to elevate mood) 100 mg once daily, due to the tremors.

Review of Resident 1's progress notes dated 11/22/2023 showed that the resident became dizzy and fell, hitting their head. The note showed that Resident 1 had suffered a concussion due to the fall.

Review of Resident 1's progress notes dated 11/23/2023 showed that the resident fell again and hit their head on the piano.

Review of Resident 1's progress notes dated 11/25/2023 showed that the resident had fallen twice that day. The note showed that the [redacted] doctor was notified of the falls, and that they ordered the reduction of the Resident's Benztropine from 1 mg twice daily to 0.5 mg twice daily.

Review of Resident 1's Physician's Orders showed an order dated 07/20/2023, that their Buproprion 300 mg daily was to be stopped due to the resident starting the Auvelity (to treat depression) medication.

Resident 1's October 2023 MAR showed that the Buproprion 300 mg daily was handwritten onto the MAR and was signed for daily from 10/1/2023-10/12/2023 and again on 10/15/2023. The MAR entry had no further initials indicating the medication had been given for the remainder of October, and it was not discontinued from the October MAR.

Review of Resident 1's Physician's Orders showed an order dated 11/06/2023 to change their Invega injection from once every 30 days to once every 21 days.

Review of Resident 1's November and December 2023 MARs showed that the 11/06/2023 order to change the Invega injection to every 21 days was not changed on the MAR. The MARs showed that Resident 1 received the injection on 11/15/2023, and 30 days later on

12/15/2023.

Review of Resident 1's Physician's Orders showed an order dated 11/17/2023 to change their Auvelity 45-105 mg from twice daily to once daily for seven days only then discontinue, due to restarting Buspirone.

Resident 1's November 2023 MAR showed that the 11/17/2023 change to the Auvelity was not added to the MAR. The MAR showed that the Auvelity was given twice daily from 11/17/2023 through 11/26/2023. Additionally, it showed that the Auvelity was not given once daily for seven days as ordered.

Review of Resident 1's Physician's Orders showed an order dated 11/16/2023 to start Ingrezza 40 mg daily (to treat the adverse side effects of antipsychotic medications).

Review of Resident 1's 11/01/2023 - 12/15/2023 MARs showed that the Ingrezza 40 mg daily had not been entered onto the MARS, indicating the medication had not been started for the resident.

Review of Resident 1's Physician's Orders showed an order dated 11/25/2023 reduce Benztropine from 1 mg twice daily to 0.5 mg twice daily, and another order dated 11/28/2023 to discontinue Benztropine 0.5 mg due to their dizziness and repeated falls.

Resident 1's MAR showed that the Benztropine 1 mg twice daily dose was given until 11/24/2023 and then it was discontinued from the MAR. The 11/27/2023 order to decrease the medication to 0.5 mg was never added onto the MAR. The MAR showed that Resident 1 did not receive Benztropine 0.5 mg twice daily from 11/25/2023 -11/28/2023.

Additionally, Review of Resident 1's October 2023 MAR showed that 15 doses overall of their prescribed medications were not initialed as being given as ordered. Review of Resident 1's November 2023 MAR showed that 17 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Resident 3

Review of Resident 3's 11/07/2023 admission assessment showed that the resident had diagnoses that included [redacted], [redacted], [redacted], and [redacted]. Additionally, it showed that Resident 3 required twice daily blood glucose monitoring and administration of insulin (medication to regulate blood sugars) injections.

Review of Resident 3's Physician's Orders, dated 10/01/2023, showed that the resident was prescribed Erythromycin (to reduce eye infection) ointment four times daily, insulin four times daily, Apixaban (blood thinner) twice daily, Carboxymethylcellulose drops

(medication for eye irritation), Olanzapine (mood stabilizer), and Rifaximin (anti-biotic).

Review of Resident 3's November and December 2023 MARs showed that their eye ointment was to be applied, and their blood sugar was to be checked, four times daily. The MAR showed that the fourth dose of ointment was not applied, and the fourth blood sugar check was not completed as ordered.

Additionally, Review of Resident 3's November 2023 MAR showed that 37 doses overall of their prescribed medications were not initialed as being given as ordered. Resident 3's December 2023 MAR showed that 20 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Resident 6

Review of Resident 6's NSA dated 02/22/2023 showed that they had diagnoses of [redacted], and [redacted].

Review of Resident 6's Physician's Orders dated 10/01/2023, showed that they were prescribed Atorvastatin (to lower cholesterol levels), Brimonidine (an eye drop for eye disease), Dorzolamide (an eye drop to lower pressure in the eye related to eye disease), Clopidogrel (blood thinner), Meloxicam (to reduce pain and swelling), Metoprolol (to lower blood pressure), Tiotropium bromide (for opening airways), Entresto (for heart failure), Symbicort (reduces inflammation in the lungs), Latanoprost (an eye drop for eye conditions that cause blindness), and Valsartan (for high blood pressure and heart failure).

Review of Resident 6's September 2023 MAR showed that 80 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Review of Resident 6's October 2023 MAR showed that 73 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Review of Resident 6's November 2023 MAR showed that 165 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Review of Resident 6's 12/01/2023- 12/15/2023 MAR showed that 9 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Resident 2

Review of Resident 2's NSA dated 08/05/2023 showed that they had diagnoses of [redacted], and [redacted]. Additionally, the

NSA showed the resident needed staff assistance with taking their medications.

Review of the facility Physician Orders dated 10/01/2023 showed Resident 2 received three medications to regulate their blood sugar, five medications to manage mental illness symptoms, one medication to manage symptoms for the brain injury and three medications to regulate their blood pressure.

Review of Resident 2's October 2023 MAR showed that 63 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Review of Resident 2's November 2023 MAR showed that 41 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Review of Resident 2's 12/1/2023-12/15/2023 MAR showed that 42 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

Resident 5

Review of Resident 5's NSA dated 09/13/2023 showed that the resident had diagnoses of [redacted], and [redacted]. Additionally, the NSA showed that the resident needed staff assistance with taking their medications.

Review of Resident 5's Physician's Orders dated 10/01/2023 showed that the resident was prescribed Glipizide and Metformin (medication to regulate blood sugar), Olanzapine (medication to manage Schizophrenia symptoms) and Lisinopril (medication to regulate blood pressure).

Review of Resident 5's September 2023 MAR showed that 41 doses overall of their prescribed medications were not initialed as being given as ordered. The MARs did not show documentation as to why the medications were not initialed as being given.

On 12/13/2023 at 11:00 AM, Staff B, Assistant Manager, stated that it was the responsibility of Staff A, Registered Nurse (RN)/Assistant Manager, to transcribe any new orders onto the residents' MARs when orders were received.

On 12/15/2023 at 11:29 AM, Staff G stated that Staff A, RN, was responsible to type all order entries onto the MARs each month and to write in any new orders when received. Staff G stated that if a medication was not signed for on the MAR, the staff should be documenting the reason on the back of the MAR page.

On 12/19/2023 at 3:15 PM, Staff D, Caregiver, stated there were times residents would run

out of their medications. They stated there would be a delay in getting the medications to the facility and some residents had to go without their medications. Additionally, Staff D stated that they had concerns with the MARs and that they had to meet with Staff A, RN, daily for clarification.

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 Sunnyside 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-2300 Food and nutrition services.

(1) The assisted living facility must:

(g) Make available and give residents alternate choices in entrees for midday and evening meals that are of comparable quality and nutritional value. The assisted living facility is not required to post alternate choices in entrees on the menu one week in advance, but must record on the menus the alternate choices in entrees that are served;

(3) The assisted living facility may provide to a resident at his or her request and as agreed upon in the resident's negotiated service agreement, nonprescribed:

(a) Modified or therapeutic diets;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide a modified diet for 1 of 1 resident (Resident 3) reviewed for nutrition services. This failure resulted in Resident 3 not receiving their prescribed modified diet and placed the resident at risk of choking and aspiration (accidentally inhaling food or other particles into the lungs).

Findings included…

Resident 3

Review of Resident 3's hospital records dated 11/05/2023 showed the resident was at increased risk of aspiration and was to receive a prescribed diet of a mechanical soft (finely chopped) food and nectar thick (thickness of honey) liquid diet.

Review of the facility's record showed the Resident 3 admitted to the ALF on [redacted]/2023.

Review of Resident 3's Negotiated Service Agreement (NSA), dated [redacted]/2023 showed Resident 3 had diagnosis of [redacted] and required a diabetic (carbohydrate and/or sugar controlled) and mechanically altered diet. The NSA did not include directive of thickened liquids or if the resident was independent or needed supervision during meals.

During an observation on 12/11/2023 at 12:34 PM Resident 3 was being assisted with the noon meal by Staff J, Caregiver. Staff J was feeding the resident cubed pieces of beef steak that were one inch by one inch in size, and whole shoestring style green beans. Resident 3 was dropping food out of their mouth and unable to chew the food.

On 12/11/2023 at 12:34 PM, Resident 3 stated that the food was hard to eat. Staff J cut up the beef steak into quarter inch pieces and cut the green beans in thirds.

On 12/12/2023 at 11:40 AM, observation showed a sign posted on the wall in Resident 3's room that stated, "Diet: Mechanical soft/Liquids: Nectar thick by teaspoon".

On 12/12/2023 at 11:41 AM, Resident 3 was given a cup with a thin red liquid that was waterlike consistency.

On 12/12/2023 at 11:58 AM, Staff E, Caregiver, stated that Resident 3's was drinking sugar free juice that was not thickened liquid.

On 12/12/2023 at 1:45 PM Staff G, Regional Supervisor, stated that the facility did not have thickened liquids available for Resident 3 and was not aware of their therapeutic diet.

On 12/13/2023 at 3:56 PM, Staff H, Regional Registered Nurse, acknowledged that Resident 3 had physician's orders for a mechanical soft diet and thickened liquids.

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 Sunnyside 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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(b) Nurse delegation, if provided;

(c) Initial and on-going assessments of the nursing needs of each resident;

(d) Development of, and necessary amendments to, the nursing component of the negotiated service agreement for each resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that the Registered Nurse (RN) Delegator followed the requirements for nurse delegation which included obtaining consent, assessing the resident, and providing directions for each task, and reviewing the appropriateness of continuation of delegation, and those who received delegated task assistance from staff for 4 of 4 residents (Residents 1, 2, 3, 6). This failure placed residents at risk of complications of their medical conditions and potential for delegated tasks to be performed incorrectly.

Findings included…

WAC 246-840-010(12) "Delegation" means the licensed nurse transfers the performance of selected nursing tasks to competent individuals in selected situations. The nurse delegating the task is responsible and accountable for the nursing care of the resident. The nurse delegating the task supervises the performance of the unlicensed person.

Review of WAC 246-840-930, Criteria for delegation, showed that the RN was to assess the resident for the need and appropriateness for each delegated task and obtain written consent from the resident or their representative for the delegation. Additionally, the RN had to provide training and direction to qualified staff and ensure that reevaluation and documentation of delegated tasks occurred for the first four weeks for insulin, and at least every 90 days for all delegated tasks.

On 12/11/2023 at 9:31 AM Staff G, Regional Supervisor, stated that the facility provided intermittent nursing services to residents, which included delegation of medications and treatments.

Resident 1

Review of Resident 1's 03/10/2023 assessment completed by Staff A, RN/Assistant Manager, showed that the resident required administration from the staff of a weekly injection to treat diabetes (a disease which the body does not properly regulate blood sugar levels in the bloodstream), and daily blood sugar checks (to monitor levels of sugar in the bloodstream).

Review of Resident 1's Negotiated Service Agreement (NSA) dated 03/10/2023 showed that the resident had diagnoses which included [redacted], [redacted] ([redacted]), and [redacted].

Review of Resident 1's department assessment dated 08/17/2023 showed that the resident had a history of diabetes, seizures (involuntary and controlled spasms and movements of the body) and a stroke. The assessment showed that Resident 1 required daily blood sugar testing by the staff.

Review of Resident 1's October 2023, November 2023, and December 2023 Medication Administration Records (MARs) showed that the resident required blood sugar checks to be done every morning. The MARs did not show documentation that the blood sugar checks had been done or what the results were. Additionally, Resident 1's MARs did not show that they were prescribed a weekly injection for their diabetes.

Review of Resident 1's physician's order dated 11/21/2023 showed that the resident's laboratory blood work indicated that their blood sugar levels over a three-month period were in the high-risk range, indicating inadequate control of their diabetes and increased risk of complications from the disease.

Review of Resident 1's facility's nurse delegation records showed a consent for nurse delegation for the resident signed and dated on 11/22/2023 by Staff A, RN. The consent showed that Resident 1 had a diagnosis of [redacted]. The consent was not signed by Resident 1 or their representative. The consent did not identify what task required delegation for Resident 1. There were no other nurse delegation records documented for Resident 1. There were no nurse delegation records to show that the RN had provided training and direction to qualified staff.

On 12/13/2023 at 09:20 AM, Staff H, Regional RN, stated that they assumed that Staff A, RN, added blood sugar testing to Resident 1's MARs when the resident's doctor restarted them on an oral diabetic medication after the high blood sugar testing results were found. Staff H, RN, stated that they had not seen a doctor's order to check Resident 1's blood sugars, but that they had faxed the doctor for one.

Review of a facility blood sugar tracking log showed that no blood sugars were tested for Resident 1 throughout 10/1/2023-12/13/2023. The log showed blood sugars were checked twice daily starting on 12/14/2023.

Resident 2

Review of Resident 2's assessment dated 06/14/2023 showed that the resident required staff assistance with medication and blood sugar checks.

Review of Resident 2's NSA dated 08/05/2023 showed that the resident had a diagnosis of [redacted] and required blood sugar checks. The NSA did not show the plan for who was responsible to check Resident 2's blood sugar. The NSA showed that Resident 2 required staff assistance with topical creams.

Review of Resident 2's Physician's Orders dated 10/01/2023, showed that the resident was to have their blood sugar checked every day.

Review of Resident 2's October and November 2023 MARs did not show that the resident's blood sugars were to be monitored. The MAR did not show documentation that the blood sugar checks had been done.

Review of Resident 2's facility delegation form titled, "Nurse Delegation: Instructions for Nursing Task," completed by Staff H, RN, on 10/01/2023 showed that the resident required delegation assistance for the application of creams. There were no delegation forms to show that staff were delegated to do blood sugar checks.

Resident 3

Review of Resident 3's admission assessment dated 11/07/2023 showed that the resident had diagnoses that included [redacted] ([redacted]), and [redacted]. Additionally, it showed that Resident 3 required twice daily blood glucose monitoring, administration of insulin (medication to regulate blood sugars) injections, and assistance with prescribed eye ointment and eye drops.

Review of Resident 3's Physician's Orders dated 10/01/2023 showed that the resident was prescribed an eye ointment four times daily, insulin four times daily, medicated eye drops every four hours, and blood sugar checks four times daily.

Review of Resident 3's November 2023 and December 2023 MAR showed that the resident required blood sugar checks four times daily. However, Resident 3's MARs only showed documentation of their blood sugar being checked three times daily. Resident 3 did not have their blood sugar checked four times daily as ordered.

Review of Resident 3's facility's nurse delegation records dated 11/14/2023 showed that

the resident had a consent for nurse delegation. The consent showed that Resident 3 had a diagnosis of [redacted]. The consent did not identify what task required delegation for Resident 3. There were no other nurse delegation records documented for Resident 3.

Resident 6

Review of Resident 6's assessment dated 03/09/2023 showed that the resident required staff assistance with medication and eye drops.

Review of Resident 6's NSA dated 02/22/2023 showed that the resident had a diagnosis of [redacted], and [redacted]. The NSA showed that Resident 6 required staff assistance for oral medications. Resident 6's NSA did not include administration for eye drops.

Review of Resident 6's facility nurse delegation records showed that the form, "Nurse Delegation: Nurse Visit" was completed by Staff H, RN on 02/22/2023, which was not updated within 90 days as required.

On 12/13/2023 at 11:40 AM, Staff H, RN, stated that Staff A, RN, was responsible for doing the nurse delegation for the ALF, but from what documents they had seen, it was not being done properly. Staff H, RN, stated that Staff A, RN, was not obtaining signed consents, not identifying the resident specific delegated nursing tasks and directions for staff, and was not verifying staff credentials.

On 12/13/2023 at 11:54 AM, Staff C, Caregiver, stated they had worked shifts where no nurse or delegated medication technician (caregiver approved to administer certain medications) was available and that Staff A, RN, was aware. Staff C stated that they had had to give medications and insulin to the residents themselves on those shifts. Staff C stated they were not delegated to do these tasks.

Additionally, Staff C stated they had worked with Staff A, RN, on 11/11/2023 and they stated that Staff A showed them how to administer medications and insulin. They stated Staff A did not do a formal delegation training with them. Staff C stated that on 11/12/2023, Staff A was not working in the facility and there was not a delegated medication technician either. Staff C stated they had to administer medications and insulin to all residents themselves.

On 12/13/2023 at 3:05 PM, Staff H, RN, stated that they observed Staff A, RN, provide only one day of medication training and then allowed the caregiver to do the tasks. Staff H stated they asked Staff A about it and was told that the caregiver would be able to do it.

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 Sunnyside 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-2350 Coordination of health care services.

(1) The assisted living facility must coordinate services with external health care providers to meet the residents' needs, consistent with the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to coordinate service referrals when a resident required outside agency services for 1 of 1 resident (Resident 3). This failure resulted in Resident 3 not receiving treatments as ordered including wound care, physical therapy and speech therapy.

Findings included…

Review of the Assisted Living Facility (ALF) policy dated 03/2017 titled, “Disclosure of Services Required by RCW 18.20.300” showed that the facility must coordinate services as ordered by the resident’s health care provider.

Review of Resident 3’s hospital notes dated 11/05/2023 showed that the resident had had a feeding tube removed from their abdomen. Additionally, the discharge note showed that Resident 3 had referrals made to home health for wound care, physical therapy and speech therapy services.

Review of Resident 3’s facility admission assessment dated 11/07/2023 showed that the resident was admitted with diagnoses that included [redacted], [redacted], [redacted] ([redacted]), and [redacted].

Review of Resident 3’s facility skin assessment dated [redacted]/2023 showed that the resident was admitted with four wounds which included a large wound on their lower leg.

Review of Resident 3’s admission orders dated [redacted]/2023 showed that the resident had a

modified diet of mechanical soft foods, nectar thick fluids, and a diabetic diet.

Review of Resident 3's initial Negotiated Service Agreement (NSA) dated [redacted]/2023, showed that the resident required extensive two-person assistance for transfers, required the use of a wheelchair for mobility, was blind, had brain damage and was prescribed a modified diet. The NSA showed that the resident required monitoring for skin integrity and had a, "big infected wound on the right leg" the NSA showed the wound required daily cleaning and dressing by a nurse.

Review of Resident 3's progress notes dated 11/16/2023 showed that the wound on their right lower leg was, "black in the center".

Review of Resident 3's progress notes dated 11/19/2023 showed that the resident could not stand up and that their ankle was swollen, bent inward and they were, "in great pain."

Review Resident 3's hospital records dated [redacted]/2023 showed that the resident was admitted to the hospital for a fractured ankle.

Review of Resident 3's hospital progress note dated [redacted]/2023 showed that the resident needed physical therapy.

Review of Resident 3's Hospital Discharge Summary dated [redacted]/2023, showed that the resident was discharged back to the ALF with an order for six weeks of antibiotics for their infection and needed to be non-weight bearing on their right leg.

On 12/12/2023 at 2:40 PM, Staff G, Regional Supervisor, stated that Resident 3 was to receive home health for physical therapy, speech therapy and wound care. They stated that referrals were sent to the facility in early November. They confirmed that no services had been started as of 12/12/2023.

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 Sunnyside 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-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to investigate, determine the circumstances of the event, put preventative measures in place for accident or incident for 3 of 4 residents (Residents 3, 5, 6). These failures placed the residents at risk of abuse and neglect and at risk of further incidents that could negatively impact their health or life.

Findings included…

Review of the facility's policy titled, Elopement/Missing Resident Policy, undated, showed the ALF procedure if a resident left the facility. The procedure included notifying law enforcement, description of the resident, description of the situation, completing an online report to the department, and notifying resident representative, case manager, physician. Additionally, the policy stated to complete an incident report.

Resident 3

Review of Resident 3's Negotiated Service Agreement (NSA), dated 12/08/2023 showed that the resident had diagnoses of [redacted].

Review of Resident 3's progress notes dated 11/18/2023 showed that the resident stated that their right foot hurt. Additionally, the record stated the resident had difficulty getting on the toilet.

Review of Resident 3's progress notes dated 11/19/2023 showed that the resident could not stand up and that their ankle was swollen, bent in at the ankle and they were, "in great pain."

Review Resident 3's hospital records dated [redacted]/2023 showed that the resident was admitted to the hospital for a fractured ankle.

Review of Resident 3's hospital records dated [redacted]/2023, showed the physician discussed Resident 3's ankle fracture with the resident's representative. The document showed the representative had visited the resident two weeks before and that the ankle was not injured at that visit.

Review of Resident 3's hospital records dated [redacted]/2023, showed that the resident was, "unclear about how [Resident 3] has sustained injury."

Review of Resident 3's hospital records dated [redacted]/2023, showed the physician did not know the nature of the trauma to Resident 3's ankle.

On 12/12/2023 review of Resident 3's medical record at the facility did not show any documentation of how the resident's ankle injury occurred.

On 12/14/2023 at 11:45 PM, Staff B, Assistant Manager, stated that they could not say why an incident report was not completed for Resident 3 and that the incident was not reported to the Complaint Resolution Unit (CRU).

On 12/11/2023 at 10:19 AM, Staff G, Regional Supervisor, acknowledged that Resident 3 had an ankle injury and had been at the hospital.

On 12/14/2023 at 2:06 PM, Staff G stated that an investigation regarding Resident 3's ankle injury was not completed. There was no investigation to determine the circumstances of the injury and there was not a plan implemented to prevent another occurrence.

Resident 5

Review of the NSA dated 09/13/2023, showed Resident 5 had diagnoses that included a [redacted] and [redacted]. The NSA showed that Resident 5 was able to walk independently, and that staff were to monitor the resident's ability to be outside alone. Additionally, the NSA did not show if the resident was able to leave the facility unescorted.

Review of Resident 5's progress notes dated [redacted]/2023 showed the resident was told that transportation could not be arranged to an appointment scheduled for that day. The resident became agitated, packed their suitcase, and left the ALF. The documentation showed that staff did not stop the resident because they had, "Agitated facial expressions".

On 12/11/2023 at 9:40 AM, Staff G stated that Resident 5 had recently left the facility unescorted and that they were unaware of the resident's current location. They stated that the resident had stopped taking their medications and their behaviors had worsened, prior to them leaving the facility. Additionally, they stated that the facility's process for a resident who left unescorted, was to assess the resident for the ability to safely leave the facility and update the NSA.

Review of the facility's Incident Report dated [redacted]/2023, showed that Staff E, Caregiver, initiated a report about Resident 5 leaving the facility that day. The report was incomplete and did not show that an investigation had been done.

On 12/14/2023 at 3:30 PM, Staff G stated that the facility's nurse should have done an investigation about Resident 5 leaving the ALF on [redacted]/2023.

Resident 6

Review of Resident 6's NSA, dated 02/22/2023 showed Resident 6 had diagnoses of [redacted], and [redacted].

Review of Resident 6's progress notes dated 09/10/2023 showed that the resident had a fall.There was no time indicated on the note. Additionally, there was no documentation with the details or circumstances of the fall.

Review of Resident 6's record did not include an investigation for the fall that occurred on 09/10/2023. There was no documentation that showed the resident was monitored and that a plan was implemented to prevent another fall.

On 12/18/2023 at 3:30 PM, Staff G stated that they had not found an investigation for Resident 6's fall.

Review of Resident 6's progress notes dated 09/30/2023 showed that the resident had bruising on their buttocks. Additionally, there was no documentation with the details or circumstances of the bruising.

Review of Resident 6's record did not include an investigation for the bruising that staff had discovered on 09/30/2023.

Review of Resident 6's record for September 2023 - December 2023 showed no documentation of a report to CRU.

On 12/18/2023 at 3:30 PM, Staff G stated that they had not found an investigation for Resident 6. They acknowledged that they were not able to rule out abuse and neglect for Resident 6.

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 Sunnyside 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-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure a Washington state name and date of birth background check was submitted every two years for staff that had worked in the ALF for more than two years for 1 of 1 staff (Staff E). This failure placed residents at risk of being cared for by disqualified staff.

Findings included…

Staff records were reviewed on 12/13/2023 at 1:09 PM with Staff B, Assistant Manager. They stated that they were responsible for maintaining and updating staff records, along with Staff A, Registered Nurse (RN)/Assistant Manager.

On 12/13/2023 at 1:25 PM record review of the business file for Staff E, Caregiver, showed that they had been hired on 11/11/2020. Staff E's file showed that they had a Washington state name and date of birth background check result on 02/14/2023. Staff E's file did not show that any other Washington state name and date of birth background checks had been completed.

On 12/15/2023 at 12:50 PM, Staff G, Regional Supervisor, stated that there was not a Washington state name and date of birth background check on file for Staff E had not been done every two years as required.

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 Sunnyside 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-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff had their Washington state name and date of birth background check submitted to the department within one business day of hire for 3 of 5 staff (Staff B, D, F). This failure

placed residents at risk for being cared for by disqualified staff.

Findings included…

Staff records were reviewed on 12/13/2023 at 1:09 PM with Staff B, Assistant Manager. They stated that they were responsible for maintaining and updating staff records, along with Staff A, Registered Nurse (RN)/Assistant Manager.

Review of Staff B's business file showed that they were hired on 02/01/2022. Their file showed that a Washington state name and date of birth background check was submitted to the department on 03/09/2022, which was 36 days after their date of hire.

Review of Staff D's business file showed that they were hired on 07/10/2023. Their file showed that a Washington state name and date of birth background check was submitted to the department on 07/18/2023, which was 8 days after their date of hire.

Review of Staff F's business file showed that they were hired on 02/01/2022. Their filed showed that a Washington state name and date of birth background check was submitted to the department on 06/28/2022, which was 147 days after their date of hire.

On 12/15/2023 at 12:50 PM, Staff G, Regional Supervisor, acknowledged that Staff B, D, and F did not have their Washington state name and date of birth background checks submitted to the department within one business day.

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 Sunnyside 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-2560 Administrator responsibilities. The licensee must ensure the administrator:

(1) Directs and supervises the overall twenty-four-hour-per-day operation of the assisted living facility;

(2) Ensures residents receive adequate care and services that meet the standards of this chapter;

(3) Is readily accessible to meet with residents;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) licensee failed to ensure the administrator was readily accessible to the residents and provided direction and supervision of the daily operations of the ALF. This failure contributed to a lack of oversight to ensure care was provided and systems were implemented which placed the residents at risk of unmet needs and a diminished quality of life.

Findings included…

Review of the department's Facility Management System on 12/11/2023 showed that Staff F was identified as the facility's designated administrator as of 03/23/2022.

Review of the facility's Disclosure of Services, undated, showed Staff F, Administrator as the main point of contact for the facility.

On 12/11/2023 at 9:31 AM, Licensors entered the ALF and were greeted by Staff E, Caregiver, and Staff J, Caregiver. Staff E stated that they were the only two staff working in the ALF, there was no administrator on site. Staff E stated that they would call Staff G Regional Supervisor, who was out of the area, to speak with the licensors.

In a telephone interview on 12/11/2023 at 9:34 AM, Staff G stated that Staff A, Registered Nurse (RN)/Assistant Manager, was in charge of the facility and that Staff A, RN, was on vacation from 12/09/2023 – 12/18/2023. Staff G stated that Staff B, Assistant Manager, was in charge of the facility in Staff A, RN's, absence. Additionally, Staff G stated that they were not able to be onsite during the inspection and would need to gather information and documents remotely.

During the resident group meeting which occurred on 12/12/2023 at 10:50 AM, six unnamed residents attended the meeting. The residents did not identify the facility's administrator (Staff F) or name them as a person who was available for their concerns.

Review of the facility's staff roster, undated, showed facility staff names and phone numbers. The roster did not show Staff F name listed or their contact information.

During an observation on 12/12/2023 at 11:00 AM, Staff B arrived onsite at the ALF, and stated that they had driven there from a city three hours away from the ALF.

In a telephone interview on 12/12/2023 at 3:26 PM, Staff G stated that Staff B had only been at the facility about one day per week since July 2023.

On 12/13/2023 at 11:05 AM, Staff B stated that Staff F came onsite to the ALF, "about twice per month" and did not live within close proximity of the facility.

In a telephone interview on 12/13/2023 at 3:10 PM, Staff G stated that Staff F came to the facility monthly and that, "on paper everything looked fine" and that both she and Staff F thought that the operations at the facility were running properly.

In a telephone interview on 12/13/2023 at 3:43 PM, Staff G stated that they recognized

safety concerns at the ALF and were remotely creating a plan to ensure the immediate safety of the residents.

Refer to Washington Administrative Code (WAC) 388-78A-2100, WAC 388-78A-2120, WAC 388-78A-2210, and WAC 388-78A-2300.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to make a report to the Complaint Resolution Unit (CRU) when injuries of an unknown source were obtained for 2 of 2 residents (Residents 3, 6). This failure resulted in a delayed investigation by the department and placed the residents at risk for further abuse.

Findings included…

Review of Revised Code of Washington (RCW) 74.34.035 titled, “Reports—Mandated and permissive—Contents—Confidentiality” showed that mandated reporters should report to the department when a vulnerable adult had an injury that occurred on the buttock or when a fracture was sustained.

Review of the facility’s policy titled, “Abuse, Neglect and Exploitation,” undated, stated that the administrator, caregivers, and staff providing care and services to residents are mandated reporters. Additionally, mandated reporters are required to report to the department when there is a reasonable cause to believe that abuse or neglect of a

vulnerable adult has occurred.

Resident 3

Review of Resident 3's initial Negotiated Service Agreement (NSA) dated [redacted]/2023 showed that the resident had diagnoses of [redacted]. Resident 3's NSA showed that the resident used a wheelchair and required, "extensive" caregiver support for mobility.

Review of Resident 3's progress notes dated 11/18/2023 showed that the resident stated that their right foot hurt. Additionally, the record stated the resident had difficulty getting on the toilet.

Review of Resident 3's progress notes dated 11/19/2023 showed that the resident could not stand up and that their ankle was swollen, bent inward, and they were, "in great pain."

Review Resident 3's hospital records dated [redacted]/2023 showed that the resident was admitted to the hospital for a fractured ankle.

Review of Resident 3's hospital records dated [redacted]/2023 showed that the resident was, "unclear about how [Resident 3] has sustained injury."

On 12/14/2023 at 11:45 AM, Staff G, Regional Supervisor stated that a report had not been made to the CRU and that abuse and neglect had not been ruled out for Resident 3.

Resident 6

Review of Resident 6's NSA, dated 02/22/2023 showed that the resident had diagnoses that included [redacted].

Review of Resident 6's progress notes dated 09/30/2023 showed that the resident had bruising on their buttocks. Resident 6's record showed no documentation with the details or circumstances of the bruising.

On 12/18/2023 at 3:30 PM, Staff G stated that they had not found an investigation summary or documentation of reporting to CRU for Resident 6. They acknowledged that they were not able to rule out abuse and neglect for Resident 6.

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