STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Sabra West Coast Operations V, LLC
Ashley Pointe Senior Living
11117 20TH ST NE
LAKE STEVENS, WA 98258

RE: Ashley Pointe Senior Living License # 2643

Dear Administrator:

This letter addresses Compliance Determination(s) 41846 (Completion Date 05/28/2024) and 33740 (Completion Date 04/05/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/28/2024 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-2371-1, WAC 388-78A-2371-3, WAC 388-78A-2170-1, WAC 388-78A-2170-2-b, WAC 388-78A-2170-2-c, WAC 388-78A-2150-1, WAC 388-78A-2150-2, WAC 388-78A-2210-2-a, WAC 388-78A-2210-1-b, WAC 388-78A-2930-1-b-i, WAC 388-78A-2090-1-a, WAC 388-78A-2090-1-b, WAC 388-78A-2090-1-c, WAC 388-78A-2090-1, WAC 388-78A-2090-6-e, WAC 388-78A-2090-8-b-i, WAC 388-78A-2090-8-b-ii, WAC 388-78A-2090-8-b, WAC 388-78A-2090-9, WAC 388-78A-2290-3, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-e, WAC 388-78A-2290-4, WAC 388-78A-2290-4-a, WAC 388-78A-2290-4-b, WAC 388-78A-2290-4-c, WAC 388-78A-2290-4-d

The Department staff who did the on-site verification:
Karen Glover, Complaint Investigator

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 105837
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s): 01/10/2024

Allegation(s):

1. The quality of care of care in the Assisted Living Facility (ALF) dropped due to the Executive Director (ED) forcing key staff to quit.
2. The Activity Director would not actively engage and encourage residents to participate in activities or visit them in their room.
3. The ALF had not been transporting residents to their doctor's appointment using the bus as advertised. The ALF hired an 81-year-old who could not physically climb a ladder to do maintenance or drive the bus.
4. The food at the ALF was described as inedible.
5. The ALF's care staff did not do any safety checks on their residents.
6. The Resident's rooms were not being cleaned.
7. The ALF was not giving documents when requested by the residents' representatives.

Investigation Methods:

Sample:
Total residents: 35
Resident sample size: 13
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Identified staff
Activity Director
Administrator
Residents
Family members
Housekeeping staff

Record Reviews: Incident investigation
Facility policies
Personnel files
Staff training records
Maintenance logs
Care plan
Assessment
Call logs

Investigation Summary:

1. Interview and record review indicated the residents, and the family representatives were unhappy with the care and services they received when the new Executive Director stepped in office. The ALF corporate managers met with the residents, families and representatives regarding the issues raised on the quality of care as well as the ALF's management under the Executive Director (ED). The ALF's corporate managers discussed how they were to address the complaints. The Executive Director was replaced.
2. The Activity Director was observed starting to conduct an activity, knocking on resident's doors, talking to them, and inviting them for the afternoon activity. Interview with residents indicated the ALF's staff would remind them of the activities often. The residents stated that it was their choice not to join sometimes because they wanted to be in their rooms, or they had their own activity to keep them busy.
3. Record review showed the Assisted Living Facility would provide transportation to medical appointments according to the ALF's medical appointment schedule as an optional service. Sampled residents and their representatives stated that they did not ask for transportation assistance because they bring their resident to their doctor's appointments themselves. The ALF's Operations Specialist stated that they had a licensed driver who could drive the bus when needed. The Maintenance Director's job did not usually include driving the bus. Interviewed resident reported the bus driver was aware and competent. The ALF stated that they hired a new activity staff who could also drive the bus.
4. The ALF had a weekly menu which they were following. The Menu showed they had their main dish and an alternative dish that were posted and was available for residents. The ALF hired a new Chef. The ALF dining services staff stated that their menu showed the variety of foods they were serving. Observation showed the ALF's dining servers were serving lunch to the residents. They served green salad, meat loaf with salsa toppings, and herb roasted red potatoes, corn, baked Roll and ice cream. Sampled residents (SR) stated the foods were okay and there were times that they just do not like the food. The SR stated that they could order from the alternate menu when they like.
5. The ALF caters to Assisted Living Residents and did not have memory care units. The ALF staff stated that they would check in with residents during assistance with care, when residents use their pendants to call for help, during medication assistance and during mealtimes. Records showed 3 sampled residents, who used their pendants to call for help, calls were responded up to 2221 minutes. Failed practice was identified. A citation was issued for noncompliance with WAC 788-78A-2930 (1) (b) (i) Communication system.
6. Sampled residents complained that their garbage was not consistently emptied, their rooms were not cleaned weekly, and their laundry was not done. A resident's room was observed which had their laundry overflowing, their room cluttered, empty oxygen tanks were observed laying on the floor and were not appropriately stored, furniture's were found by the foot of the bed almost blocking the exit to the door and bathroom, and the oxygen tubing was observed all over the floor. The ALF's housekeeper, who was also a caregiver, stated they were not able to clean the rooms for a week because they were asked to do caregiving tasks and there was nobody to do the housekeeping.

A citation was issued for noncompliance with WAC 388-78A-2170 (1) (2) (b) (c).
7. A family representative stated the previous Executive Director (ED) would not provide the documents they requested. The Corporate team stated families and representative were always welcome to request documents they needed. The ED was no longer working in the ALF.

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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 107071
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s): 12/08/2023

Allegation(s):

1. The Assisted Living Facility were not consistent in assisting the Named Resident (NR) in their showering and dressing them in the morning despite paying for an increase in services.
2. The ALF staff were not consistently changing the NR's clothes and been wearing the same clothes most of the time. The NR's pants smelled urine because staff were not changing them.
3. The NR's sheets were stained with fecal-like matter.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 13 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Identified staff Residents Family members
Record Reviews:	Facility policies Shower logs Resident records

Investigation Summary:

1. The NR stated they did not need any assistance with bathing and getting dressed. The NR was wearing clean clothing with no stains and her hair looked greasy. The NR's assessment showed the NR needed stand by assistance for showers which were scheduled twice a week. Interview showed the NR does not refuse shower. The ALF stated that they destroy the ALF's shower log monthly. Record review showed the ALF did not have the service plan signed by the Resident or their Legal Representative. A citation was issued for noncompliance with WAC 388-78A- 2150 (1) and (2) Signing Negotiated Service Agreement.

2. The NR was observed wearing clean clothes with no stains and no odors. The NR stated that they dress themselves and and does not need any assistance. The NR's assessment showed the NR needed reminders and checks with grooming and dressing. The ALF were following the care plan.
3. The NR's bed was observed to be neatly made. The sheets had no stains and no odors. The room look neat and tidy. Observations on Sampled residents room showed the rooms were. clean and organized.

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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 108871
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s): 12/08/2023

Allegation(s):

1. The Named Residents' (NR) mental health had greatly declined because of lack of activities, enrichment care and comfort care to the NR.
2. The ALF Staff were not following Doctor's order in applying a lidocaine patch to the NR. The ALF staff were putting it in NR's back not their knees as ordered.
3. The ALF staff wanted to put the AV on morphine and a sedative to help with the AV's anxiety when the AV needed only to be redirected and reassured.
4. The rent for AV went up but was getting very little care.

Investigation Methods:

Sample:
Total residents: 35
Resident sample size: 13
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Resident to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members
Maintenance staff
Housekeeping staff
Administrator
Activity Director

Record Reviews:
Facility policies
Call logs
Care plans
Assessments
MAR
Hospice care plan
Change of condition assessment

Care staff notes.

Investigation Summary:

1. The Assisted Living Facility (ALF) had an Activity Director (AD) at the time of the unannounced visit. The AD was observed asking and inviting residents to join them for activities. The AD was observed inviting the NR to join the afternoon activity at the time of the visit. The NR denied pain. The NR declined and stayed in their room. Interview and record review showed the ALF staff were monitoring the NR for confusion, shortness of breath and anxiety. The record showed the Family was notified of the behavior. The NR was admitted on hospice services on 11/17/2023. There were hospice orders in place for the ALF staff to ensure the NR would be comfortable.
2. Review of records showed the NR had an order for a Lidocaine patch to be applied in their right knee. The care staff observational notes showed the NR requested the ALF staff to have their Lidocaine patch to be applied in their back due to pain instead of their right knee. The ALF staff did not inform the family or the Primary Care Physician or the hospice before applying the patch on a different location. The ALF staff informed the hospice and requested to obtain a new order. Failed practice was identified for noncompliance with WAC 388-78A-2210 (1) (b) (2) (a) Medication services.
3. Interview and record review showed the NR had an ongoing confusion, pain and anxiety. The ALF staff were monitoring the NR for shortness of breath. The ALF staff had been monitoring the NR's pain and behavior and recorded their observations in their progress notes. The ALF staff administered the Morphine and medications for anxiety as ordered and implemented strategies to alleviate the discomfort such as relaxation and address the behaviors through activities and redirection. Records showed that the Ativan helped addressed the NR's anxiety and shortness of breath. During unannounced visit, the ALF staff were observing redirecting the NR. The ALF had an order from hospice for the use of Ativan for anxiety and Morphine. Interview showed the NR's family did not like the ALF staff using the Anti-anxiety medication.
4. The NR had a Change of Condition Assessment on 11/29/2023. The NR was admitted to Hospice services on 11/17/2023. Review of the Residency agreement signed on 11/14/18 showed the ALF had the discretion to effect a change in fees or rates by notifying the resident or their representative in writing not less than 30 days before the change. The ALF handed written notice to residents and their representatives regarding the planned increase in fees or rates.

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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 108491
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s):

Allegation(s):

1. The Assisted Living facility (ALF) denied a Resident, who does not [redacted] any alternative.
2. A resident ate jam packets because there were no snacks being offered. Snacks were in the activity room which is not wheelchair accessible. The refrigerator was being locked at night and resident cannot access snacks.
3. A MedTech left the medication of a resident who was on medication assistance in their walker without letting the Resident know which resulted in the resident waking up with chest pains.
4. The ALF does not have a licensed nurse.
5. The Executive Director was not certified as an administrator as required by WAC 388-112A-0060 and WAC 388-112A-0105.
6. Several employees were issued a cease-and-desist letter threatening them with legal actions and defamations and tortious interference with contractual relations simply for speaking with other employees, reporting to the state, and reporting to Corporate.

Investigation Methods:

Sample:
Total residents: 35
Resident sample size: 13
Closed records sample size: 0

Observations:
Activities
Dining
Residents
Resident rooms

Interviews:
Identified resident
Nursing staff
Residents
Family members
Housekeeping staff
Administrator

Record Reviews:
Incident investigation
Facility policies
Personnel files
Staff training records

Maintenance logs
Care plan
Assessment

Investigation Summary:

1. Interview with the Named Resident (NR) showed that they were offered alternative foods like tuna and turkey sandwich. The NR denied that there was an incident where the Assisted Living Facility (ALF) staff declined to give them alternative food. The NR stated, "It did not happen". The NR stated that they have their own oven where they can heat their own food if they do not like the food served. Interview and records review showed the NR was a [redacted] and would not [redacted] or any [redacted]. The records showed the ALF failed to to an assessment regarding the NR's preference of not [redacted] and [redacted] due to their religion. Failed practice was identified. A citation was issued for non compliance with WAC 388-78A-2090 (1)(a)(b) (c)(6)(e)(8)(b)(i)(ii) (9). Full Assessment topics.
2. The ALF had snacks available in the activity room. A variety of choices for snacks was observed displayed and open to all residents. There were 2 small fridges in the activity room. One fridge was open with puddings and Jellos. The other small fridge had a lock in it because it contained wines which needed staff supervision. Observations showed the Activity room were wheelchair accessible. Residents reported not have a problem entering the activity room with their wheelchairs.
3. The ALF failed to complete a thorough investigation to rule out abuse and neglect when informed of the allegations. The ALF was not able to provide a copy of their partial investigation. Failed practice was identified and a citation was issued for noncompliance with WAC 388-78A-2371 Investigations.
4. The ALF does not currently have a wellness nurse or director on site, but the ALF had a Regional Nurse which was accessible by phone when needed. The Regional nurse oversaw answering questions about clinical matters and would be on site when needed. The Regional nurse was the one responsible for the resident's admission, annual and ongoing assessments for change of conditions.
5. Record review showed the Executive Director (ED) did have all the required qualifications.
6. On interview, there was an employee that left who was issued the cease-and-desist letter due to persistent violation of the ALF's policy upon separation or termination from employment. There were no other employees who admitted receiving the same cease and desist letter. During the unannounced visits, the employees did not hesitate and were agreeable of the interviews during the investigation. citation was

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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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 104957
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s): 11/14/2023

Allegation(s):

1. The Named Resident (NR) had a fall. The Assisted Living Facility (ALF) did not document and did not let the family know.
2. There were concerns about the quality of food that was being served. A visitor had diarrhea after eating food from the ALF. Foods were not edible.
3. There were billing issues. The ALF raised the NR's rates against the family's objection. The Family did not sign any document in writing regarding the increase, but the ALF stated that the family did.
4. A Named resident (NR) had a fall on 10/29/2023 early in the morning and the family was not informed. They placed the NR in bed without food or drinks for the entire day.

Investigation Methods:

Sample:
Total residents: 35
Resident sample size: 13
Closed records sample size: 0

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

Interviews:
Identified resident
Nursing staff
Residents
Family members
Housekeeping staff
Business office manager
Administrator

Record Reviews:
Incident investigation
Facility policies
Personnel files
Staff training records
Maintenance logs

Care plan
Assessment
Call logs

Investigation Summary:

1. Records reviewed showed the NR's family were informed of the NR falls. The ALF failed to investigate a fall incident that happened on 11/07/2023. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2371 (1) (3) Investigations.
2. The ALF had a weekly menu which they were following. The Menu showed they had their main dish and an alternative menu that were posted and were available for residents. The ALF hired a new Chef. The ALF dining services staff stated that their menu showed the variety of foods they were serving. Observation showed the ALF's dining servers were serving lunch to the residents. They served green salad, meat loaf with salsa toppings, and herb roasted red potatoes, corn, baked Roll and ice cream. Sampled residents (SR) stated the foods were okay and there were times that they just do not like the food. The SR stated that they could order from the alternate menu when they like.
3. The ALF failed to review and have the Negotiated Service Agreement signed and dated by the resident or legal representative. Failed practice was identified for noncompliance with WAC 388-78A-2150 (1) (2). Signing Negotiated Service Agreement.
4. The NR had a fall on 08/10/2023 and the NR's representative was aware. There was no evidence of a fall on 10/29/2023. The ALF investigated the incident on 10/29/2023 and ruled out abuse and neglect. The ALF determined that the NR fell and screamed for help. The NR stated they slipped after using the bathroom. The ALF staff attended to the NR and followed their protocol. The ALF called 911 and the NR was evaluated. The ALF monitored and placed the NR on alert charting and monitoring. The NR's representative did not have any concerns about the incident. All parties were notified. No failed practice was 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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 111488
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s):

Allegation(s):
The Named Resident (NR) missed their morning prescribed medications.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 13 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Administrator
Record Reviews:	Incident investigation Facility policies Medication Administration records Care plan

Investigation Summary:
The Assisted Living Facility (ALF) investigated the incident and determined an ALF staff committed a medication error. Interview showed the Named Resident found the medications in their room when they woke up in the afternoon. The ALF determined the medications that were found were consistent with the NR's morning medications. Failed practice was identified in another sampled resident when the ALF staff were administering a medication at the wrong site. A citation was issued for noncompliance with WAC 388-78A-2210 (1) (b) (2) (a). Medication Services. Interview and records review showed the ALF failed to ensure that a family assistance for medications and treatment as well as alternate plan when the family would not be able to do it was obtained and signed by the resident, residents representative and a representative from the ALF. Failed practice was identified. A citation was issued for non compliance

with WAC 388-78A-2090 (3) (a) (b) (c)(d), (4) (a)(b)(c)(d). Family Assistance with Medications and treatments.

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: Ashley Pointe Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2643
Intake ID: 112840
Compliance Determination #: 33740
Region/Unit #: RCS Region 2 / Unit A
Investigator: Wesler Dumecquias
Investigation Date(s): 11/17/2023 through 04/05/2024
Complainant Contact Date(s): 01/09/2024

Allegation(s):

1. The Assisted Living Facility (ALF) had a problem with staffing, the Named Resident (NR) would ring their call button and it would take 1 hour for staff to respond.
2. There was a time that their room was not being cleaned for 2 weeks. There was no consistency in cleaning the room and bathroom.
3. There were days where no meals were delivered, delivered cold, late or very little.

Investigation Methods:

Sample:	Total residents: 35 Resident sample size: 13 Closed records sample size: 0
Observations:	Residents Identified resident Dining Resident rooms Kitchen
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Kitchen staff
Record Reviews:	Facility policies Call logs Care plan Dietary schedule

Investigation Summary:

1. Interview and record review showed the ALF would have scheduled 2 caregivers and 1 Med Tech to work the day and the evening shifts. The ALF would have 1 Med Tech and 1 Caregiver for the night shift. Interview and record review of call logs showed the NR had incidents of calling and there were significant delays in the staff's response

time. Failed practice was identified for noncompliance with WAC 388-78A-2730 (1) (b) (i) in relation to RCW 18.20.184 (1) Communication system.

2. Observation during the unannounced visit showed the room was clean. Interview showed there were times that there rooms were not cleaned because there was no housekeeping staff working. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2190 Housekeeping.

3. The NR were ordering their food and eating in their room per their preference. Interview showed the ALF had a system in place where the Staff were to get orders from residents who would prefer to eat in their rooms. The orders would be delivered after the staff would have taken cared of the residents who were eating in the dining room. Interview showed the NR pressed their call button and it took the ALF staff more than 30 minutes to respond and deliver their food. The ALF were actively hiring more kitchen staff. Failed practice was identified as regards the delay in the call response time. WAC 388-78A-2930 (1) (b) (i) in relation to RCW 18.20.184 (1) Communication system.

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

3906-172nd St NE, Suite #100, Arlington, WA 98223

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 11/17/2023 and 02/14/2024 of:

Ashley Pointe Senior Living
11117 20TH ST NE
LAKE STEVENS, WA 98258

This document references the following complaint number(s): 105837, 105881, 107071, 108871, 108491, 109091, 105224, 104957, 104994, 111488, 112840

The following sample was selected for review during the unannounced on-site visit: 13 of 35 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator
Christine Banta, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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-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;

(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 Interview and record review, the Assisted Living Facility (ALF) failed to investigate and document investigative actions and findings for 2 of 2 residents (Resident 1 and 2). This failure resulted in the ALF not having a thorough investigation, documentation of actions and findings to rule out abuse and neglect, identified circumstances, and identified preventative measures. This failure placed Residents 1 and 2 at risk for compromised safety and unmet needs.

Findings included...

Review of the Assisted Living Guidebook; Partners in Protection dated 02/2018, contains guidelines intended to assist facilities in developing and implementing policies and procedures to help prevent resident abuse, neglect, abandonment, significant injuries of unknown source, or personal and/or financial exploitation by any person. Chapter 2 shows all alleged incidents of abuse, neglect, abandonment, significant injuries of unknown
source, or personal and/or financial exploitation must be thoroughly investigated. For the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Review of the ALF's policy, “Fall Management and Post Fall Investigations” dated 05/15/2023 showed falls are investigated, reported, documented using the incident report and Quality Assurance Performance Improvement (QAPI) Post Fall tool. The Administrator or designee is ultimately responsible for instituting the investigation process.

Resident 1

Resident 1 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

Review of Incident Report (IR) dated 11/07/2023 showed Resident 1 had an unwitnessed fall. Resident 1 was found on the floor with a skin tear on their elbow and blood all over their carpet. The IR status was marked incomplete.

In an email on 01/31/2024 at 6:26 PM, Staff K, Clinical Operations Specialist, stated that there was no written investigation that was done for this incident.

Resident 2

Resident 2 was admitted on [redacted]/2022 with multiple diagnoses including [redacted]. Review of Negotiated Service Agreement dated 11/08/2024 showed Resident 2 was on medication assistance services.

On 11/14/2023 at 2:13 PM, Collateral Contact 1 (CC1) stated that a Medication Technician (Med Tech) left Resident 2's medication in their walker without letting them know, which resulted in Resident 2 not getting their prescribed medication. CC1 stated Resident 2 woke up with chest pains.

In an email on 01/30/2024 at 2:22 PM, Staff K, Vice President Clinical Operations, was informed of the allegation regarding staff not observing Resident 2 take their medications. Staff K stated that they would investigate the incident.

In an email on 02/06/2024 at 5:36 PM, Staff K stated they do not know who the staff was and could probably be an agency staff who was asked to work that day or an in-house staff but may no longer be working in the ALF.

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, Ashley Pointe Senior Living 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-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

(2) The assisted living facility must provide each resident with the following basic services, consistent with the resident's assessed needs and negotiated service agreement:

(b) Housekeeping - Providing a safe, clean and comfortable environment for each resident, including personal living quarters and all other resident accessible areas of the building;

(c) Laundry - Keeping the resident's clothing clean and in good repair, and laundering towels, washcloths, bed linens on a weekly basis or more often as necessary to maintain cleanliness;

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the Assisted Living Facility failed to provide and maintain a clean environment for 2 of 2 residents (Residents 11 and 14) when the ALF failed to have housekeeping services for one week. This failure resulted in residents living in unsanitary rooms with clutter, unemptied garbage cans, and overflowing baskets of dirty laundry and placed the residents' health and safety at risk.

Findings…

Resident 11

Resident 11 was admitted to the ALF on [redacted]/2019 with multiple diagnoses including [redacted], and [redacted]. The Negotiated Service Plan (NSA) dated 12/28/2023 showed personal laundry services were completed one time per week.

On 12/11/2024 at 1:15 PM, Resident 11 was observed in their motorized cart. There were three oxygen tanks on the floor by the entrance and one near their bathroom. An oxygen tank was laying on top of Resident 11's table which was beside their bed. Resident 11 was using an oxygen concentrator, and the tube lines were laying all around on the floor tangled up between their bed up to the corner where the oxygen concentrator was plugged into the wall. The tube lines were a trip hazard. The space between the bed and the corner

was used by Resident 11 to move around with their Motorized cart. Resident 11's laundry basket located in their bathroom was observed full of dirty clothes and the bathroom smelled of urine.

On 12/11/2024 at 1:15 PM, Resident 11 stated that the staff would sometimes come to clean and sometimes did not come. Resident 11 stated that there was a time nobody came to clean their room for more than 2 weeks. Resident 11 stated that the staff were not consistent in picking up and doing their laundry. Resident 11 stated that they hope the staff would come and pick it up.

On 12/11/2024 at 1:22 PM, Staff F, Medication Technician (Med Tech), stated that Resident 11's laundry days were on Tuesdays. Staff F stated that they would wait, even though the laundry was full, and leave the laundry until it was their wash day and would be washed that day. Staff F stated that they do not have exact times when they to do the laundry.

Resident 14

Resident 14 was admitted on [redacted]/2023 with multiple diagnoses including [redacted]. The NSA dated 09/06/2023 showed personal laundry services were completed one time per week.

On 12/11/2023 at 10:56 AM, Resident 14 stated that they were under the impression that laundry service was once a week. Resident 14 stated that their designated service was Thursday and that there were many times that they did not receive this service. Resident 14 stated that the laundry issue had been on and off within the month.

On 12/11/2023 at 12:41 PM, Staff E, Housekeeping, stated that she was the full-time housekeeper but also a caregiver. Staff E stated that the ALF asked her to work as a caregiver for one whole week, so nobody did the housekeeping for the week. Staff E stated there were no housekeepers on weekends.

On 12/11/2023 at 2:26 PM, Staff H, Med Tech, stated that Staff E had been asked to work as a caregiver in the last week. They stated that this resulted in a shortage in their housekeeping staff and that they were still trying to catch up. They stated that they did not have any housekeepers on the weekends and that caregivers were to empty wastebaskets in residents' rooms on those days. They stated that laundry is done on the weekends and laundry for two residents were done per shift. They stated that there had been times when residents did not have enough clean clothes to choose from.

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, Ashley Pointe Senior Living 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-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

(2) A representative of the assisted living facility duly authorized by the assisted living facility to sign on its behalf; and

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living facility (ALF) failed to have signed Negotiated Services Agreement for 3 of 3 sampled residents (Residents 1, 6, and 11). This failure resulted in Residents 1, 6, 11, and their legal representatives not reviewing and approving the services in the NSA and placed all residents with unsigned NSAs at risks for having care needs that they have not agreed to.

Findings included:

Resident 1

Resident 1 was admitted on [redacted]/2021 with multiple diagnoses including [redacted]

Review of Resident 1's NSA dated 07/03/2023 showed a signature by Staff A, Executive Director, and the ALF's representative but there was no signature from Resident 1 or their legal representative.

On 11/14/2023 at 3:02 PM, Collateral Contact 2 (CC2) stated that they had not seen, reviewed or signed any documentation from the facility regarding the care that was to be provided.

Resident 6

Resident 6 was admitted on [redacted]/2022 with multiple diagnoses including [redacted].

Review of Resident 6's NSA dated 12/01/2023 showed a signature by Staff M, Regional Director for Health and Services, and the ALF's representative but there was no signature from Resident 6 or their legal representative.

On 03/08/2024 at 9:03 AM, Collateral Contact 5 (CC5) stated that they discussed Resident 11's care in July 2023 but they only signed the care plan in December 2023.

Resident 11

Resident 11 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

Review of Resident 11's NSA dated 12/28/2023 showed a signature by Staff M, and the ALF's representative but there was no signature from Resident 2 or their legal representative.

On 03/08/2024 at 8:19 AM, Collateral Contact 9 (CC9) stated that they remembered signing a care plan when Resident 5 moved in but could not remember signing a new care plan for 12/28/2023. CC9 stated that they had been signing for Resident 5 due to their declining condition.

On 12/11/2023 at 4:05 PM, Staff K, Vice President for Clinical Operations, stated that they do not know and were not aware the NSA's were not signed.

On 01/10/2024 at 11:46 AM, Staff J, Operations Specialist stated that Staff M would do the assessments and enter in the residents' care plans. The Executive Director would usually have to sign for the ALF as representative and ensure the residents or family signs it. Staff M stated that they do not have an idea why the care plans were not signed when they should have been.

Plan/Attestation Statement

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_____ _____

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure safe medication services were provided to 2 of 3 sampled Residents (Residents 3 and 15) who were on medication assistance services. The failure resulted in Resident 3 not getting their medications as prescribed. The failure placed Resident 15 and all residents at risk of not getting their medications as prescribed and for unmet care needs.

Findings included…

Review of the ALF's policy on "Medication Management" dated 12/19/2022 showed Medication Errors procedure were as follows:
a. All medication dispensing, or administration errors will be investigated. b. All medications are to be dispensed or administrated according to prescribed physician orders.
c. When a staff member fails to dispense or administer a medication as prescribed the incident will be investigated.
d. A plan of correction will be put in place after a medication error occurs.

Review of the ALF's policy on "Medication errors" dated 03/10/2023 showed Medication assistance and/or administration will be provided to residents in a manner that is safe and consistently free of errors. Staff members who commit medication errors will receive

appropriate training, and disciplinary action, as indicated. The community will document, and will be responsible to ensure, that medications are administered without errors.

Resident 3

Resident 3 was admitted on [redacted]/2018 with multiple diagnoses including [redacted].

Review of a Negotiated Service Agreement (NSA) dated 08/17/2023 showed Resident 3 was on medication assistance and had an order for the ALF to assist with their medications. Review of Medication Administration Record dated October 2023 showed Resident 3 was ordered Lidocaine Pain Relief 4% Patch for pain on 07/19/2023 which was to be applied on their right knee every 24 hours.

On 12/08/2023 at 1:00 PM, Collateral Contact 6 (CC6) stated that they discovered that the Lidocaine patch was not on Resident 3's knee when CC6 accompanied Resident 3 to the bathroom.

On 01/10/2024 at 2:29 PM, Staff H, Med Tech stated that Resident 3 requested the lidocaine patch to be placed on their back instead of right knee. Staff D stated that they forgot to notify the PCP and request for an update in the order.

Resident 15

Resident 15 was admitted on [redacted]/2023 with multiple diagnoses including [redacted].

Review of the Medication Administration Record (MAR) showed Resident 15 was ordered DOK Oral Tablet 100 MG for constipation to be taken 2x day and Eliquis Oral Tablet 5 MG as prophylaxis to be taken 2x a day.

Review of Incident Report dated 12/21/2023 showed the ALF found medications in Resident 15's room.

Review of the ALF's Medication Error Report (MER) dated 12/21/2022 showed Resident 15 was ordered Eliquis 5 MG and DOK 100 MG to be taken 2 times per day. Staff H was the AM Med Tech. Staff D, Med Tech, was the evening med tech and found the medications in Resident 12's room. The MER showed that Staff H made the error and was written up as well as re-educated.

On 01/10/2024 at 2:16 PM, Resident 15 stated that they could not remember if they got their medication that time. Resident 15 stated that they found the medications on their table and did not have any idea who could have placed the medications on their table.

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

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:

(i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to respond within a reasonable time when 3 of 5 residents (Residents 5, 7, and 11) were using their call pendants and pull cords to request help. These failures resulted in delayed delivery of care and services for Residents 5, 7, and 11, and placed all residents using their call pendants at risk for delayed response times, unmet care needs.

Findings included…

Review of Revised Code of Washington (RCW) 18.20.184 Communication system—Telephones and other equipment showed:
(1) Each assisted living facility shall be responsive to incoming communications and respond within a reasonable time to phone and electronic messages.

Review of the ALF policy "Emergency Call Systems" dated 02/01/2024 showed communities should be equipped with an emergency call system which meets the regulatory requirements for that building. Emergency call system equipment may include, call stations buttons, pull cords, window alarms, motion sensors or intercoms.

RESIDENT 5

Resident 5 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

On 11/17/2023 at 3:41 PM, Resident 5 stated that there were not enough staff to come and help them. Resident 5 stated that they needed help with going to the bathroom, transferring, putting their clothes, and just getting up with assistance because they easily felt dizzy. Resident 5 stated that they tried to wait after pressing their call button but had to wait as long as 30 minutes to an hour before help could arrive.

Resident 7

Resident 7 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

On 12/11/23 at 11:26 PM, Resident 1 stated that they could not walk long distance because of their leg swollen and their Chronic Obstructive Pulmonary Disorder and needed to call for ALF staff mostly to order for food and delivery. Resident stated that the ALF staff were not responding immediately when they call and had to wait for sometimes up to an hour. Resident 1 stated that sometimes the ALF staff would respond in 5 to15 minutes.

Review of Resident Event Report (call log) from 11-01-2023 to 02-14-2024 showed Resident 7 had 16 events where they called for help using their pendant. The call log showed Resident 7 had pressed their pendant and the ALF staff responded from 29 Minutes to as long as 114 minutes.

On 11:46 AM 02/06/2024 at 11:46 AM, Collateral Contact 8 (CC8) stated that Resident 1 called them very upset because Resident 1 pressed their pendant calling for an ALF staff, but nobody responded. Resident 1 was calling for their food to be delivered.

On 02/14/2024 at 1:00 PM Resident 7 stated that they use their call button about 2 weeks ago around 2:00 PM to remind the ALF staff of their food delivery but there were no ALF staff responding. Resident 1 stated they had to stand up on their own, despite their swollen leg, to get to their door. They were leaning on the door frame for support and tried to look for any ALF Staff. Resident 1 stated they had to wait for more than 30 minutes until they saw an ALF staff.

Resident 11

Resident 11 was admitted on admitted [redacted]/2019 with multiple diagnoses including [redacted] and [redacted].

Review of Resident Assessment and Negotiated Service Agreement (NSA) dated 12/28/2023 showed Resident 11 was total assist with transfers and for the ALF staff to use gait belt for transfers, needed escorts for meals and activities and total assist with incontinence. The NSA showed Resident was using a motorized cart and would need help getting in and out.

On 12/11/2023 at 1:05 PM, Resident 1 stated that they used their pendant to call for help. Resident 11 stated that they call mostly for help when they needed to use the bathroom or needed to transfer. Resident 11 stated that the ALF staff would respond to their call button when they were not busy. Resident 11 stated the ALF staff do not come immediately. Resident 11 sated that there were times that they pressed their pendant and had to wait long hours for the ALF staff to come and help them.

Review of the Resident Event Report (call log) from 10-21-2023 to 12-21-2023 showed Resident 11 had 24 events where called for help using their pendant. The call log showed Resident 11 had pressed their pendant from 11 to, as many as 26 pushes and the ALF staff responded the calls from 30 minutes to as long as 2221 minutes.

On 02/14/2024 at 1:36 PM, Staff L, Med Tech stated that there were times the residents' pendants were not working properly. Staff L stated that there were care staff who would click the answer call button but did not go into the resident's room.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(1) Individual's recent medical history, including, but not limited to:

(a) A licensed medical or health professional's diagnosis, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications, or other considerations for providing care or services.

(6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including:

(e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility.

(8) Individual's level of personal care needs, including:

(b) Medication management ability, including:

(i) The individual's ability to obtain and appropriately use over-the-counter medications; and

(ii) How the individual will obtain prescribed medications for use in the assisted living facility.

(9) Individual's activities, typical daily routines, habits and service preferences.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to obtain and include sufficient information in order to assess the capabilities, needs and preferences for 3 of 3 residents (Resident 1, 7, and 11). These failures resulted in the ALF not having sufficient information to fully assess the care needs of Residents 1, 7, and 11.

Findings included...

Resident 1

Resident 1 was admitted on [redacted]/2021 with multiple diagnoses including [redacted]

Review of Ashley Pointe Observations (progress notes) dated 12/29/2023 showed Resident 1 had bilateral leg edema (swelling caused by too much fluid trapped in the body's tissues).

On 02/14/2024 at 11:55 AM, Resident 1 was observed with a swollen lower left leg and was wrapped with an ace wrap.

Review of Ashley Pointe Observations dated 01/26/2024 showed Staff M, Director of Wellness and Resident Services, noted Resident 1 keeps alcohol in there room and was allowed alcohol intake.

Review of Change of Condition (COC) assessment dated 01/08/2024 showed Resident 1 had swollen legs. The assessment failed to include information about the cause, or any diagnosis related to the swelling of the leg as well as the use of an ace wrap for the swollen leg. There was no information that was provided for the care staff to know what staff would need to be observing, what to report, when to report, and what interventions the care staff would be providing to manage the swelling. There were no details or instructions what the care staff would be doing in case the ace wrap come loose or off. The COC did not provide any information or parameters regarding Resident 1's allowable and preference of daily alcohol consumption in relation to potential interactions with their medications, their diagnoses and how care staff would monitor to ensure Resident 1 would be following any recommendations from their Primary Care Physician.

Resident 7

Resident 7 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

1. Considerations for providing care:

Resident 7 stated they do not eat [redacted] due to religious reasons.

On 01/09/2024 AT 1:55 pm, Collateral Contact 8 (CC8), stated that Resident 7 did not [redacted] and [redacted] because of religious reasons, and it was agreed upon when Resident 7 was admitted in the ALF.

On 01/10/2024 at 1:51 PM, Staff L, Dining Services Director (DSD) stated that they were not aware Resident 7 do not [redacted].

Review of "LN Assessment "dated 09/15/2021 did not show any assessment related to Resident 7's preference of not [redacted] or [redacted].

Review of the "6-months Resident Evaluation" dated 05/05/2023 did not show any assessment related to Resident 7's preference of not [redacted] or [redacted].

On 01/10/2023 at 11:40 AM, Staff J, Operations Specialist, stated they do not have an idea why Resident 7's preference of not [redacted] or [redacted] were not included in their

assessments.

Review of the Individualized Service Plan (ISP) dated 05/05/2023 showed Resident 7 was identified as a [redacted]. The ISP did not include Resident 7's preference of not [redacted].

2. Identify how medications would be obtained:

Review of Self-Administration of Medication evaluation dated 05/08/2023 showed Resident 7 could do their own medication.

On 12/11/2023 at 11:26 AM, Resident 7 stated that they do their own medication as well as order them from their own pharmacy.

Review of the "6-Month Resident Evaluation" (used to assess residents needs) dated 05/05/2023 showed resident 7 had an order to independently self-medicate. The evaluation did not include sufficient information on how Resident 7 would obtain or refill their prescribed medications, Resident 7's ability to appropriately use over the counter medications, and on how Resident 7 would ensure their medications were locked or safely secured. The evaluation failed to identify, ensure and show how Resident 7's preference of not [redacted] would be respected.

Resident 11

Resident 11 was admitted on admitted [redacted]/2019 with multiple diagnoses including [redacted] and [redacted].

1. Assessment for the use of a motorized wheelchair.

Review of the "6 - month Resident Evaluation" dated 06/23/2023 showed Resident 11 was using a "Powered wheelchair". There were no details or assessments for the safe use as well as maintenance of a motorized assistive device.

On 12/11/2023 at 1:05 PM, Resident 11 was observed seated on a motorized wheelchair which they used for mobility.

On 12/11/2023 at 4:05 PM, Staff K, Vice President for Clinical Operations, stated that they were going to look for an assessment for Resident 11's use of the motorized wheelchair.

On 01/10/2023 at 11:40 AM, Staff J, Operations Specialist, stated that Resident 11 did not have an assessment for the use of the motorized wheelchair since Resident 11 started using it. Staff J stated that they just completed an assessment for Resident 11's use of the motorized cart but Resident 11 did not pass. Staff J stated that Resident 11 was not safe to use the motorized wheelchair and should be using a manual wheelchair.

Review of Assistive Motorized Device Safety Evaluation dated 12/28/2023 showed Resident 11 did not understand the safe operation of the speed controls of the assistive motorized device. The evaluation was completed 13 days after the ALF was made aware of the need for an assessment.

2. Use of Oxygen concentrator and Portable oxygen.

On 12/11/2023 at 1:05 PM, Resident 11 was observed using oxygen therapy via a nasal canula connected to an oxygen concentrator. There were 3 portable oxygen tanks placed beside their bed.

Review of "6-Month Resident Evaluation" dated 12/28/2023 showed Resident 11 uses an oxygen concentrator in their room. There were no details or assessments for the safe use of oxygen therapy as well as any information as to how the portable tanks were to be stored and who would be responsible for the refill.

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

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

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

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

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

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

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

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

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 2 of 3 residents (Residents 8 and 12) who managed their own medications, obtained a written family assistance plan. These failures resulted in the residents not having a written family plan and an alternative plan identified if the primary plan failed and placed the residents at risk for complications and unmet care needs.

Findings included…

Record review of the ALF's blank and undated Family Assistance with Medications form showed in accordance with WAC 388-784-229, this assisted living may permit a resident's family member to administer medications or treatments, or to provide medication or treatment assistance, including obtaining medication or treatment supplies, to the resident. All of the following will be followed for this to be permitted in this community.
Name and phone number of family member who will provide the medication or treatment assistance:
Description of assistance or administration that the family member will provide:
Alternate plan if the family member is unable to fulfill his or her duties as specified in this plan:
Emergency contact person and telephone number:
Secondary contact person and telephone number.

Resident 8

Resident 8 was admitted on [redacted]/2022 with multiple diagnoses [redacted]

Review of the Self – Administration of Medication Evaluation dated 05/15/2023 showed Resident 8 was assessed as being able to self-administer their medications.

On 02/14/2024 at 1:18 PM, Resident 8 stated that they were ordering their own medications from their own pharmacy and then a family member would bring it to them in the ALF. Resident 8 stated that there was never any mention about an agreement regarding their family's participation in obtaining their medications and they could not recall signing anything. Resident 8 stated that from now on, hospice would be helping them in obtaining and refilling their medications.

In an email on 01/31/2023 at 10:25 AM, Staff K, Vice President for Clinical Operations, stated that hospice (initiated on 08/02/2023) was ordering and setting up medications for Resident 8. Staff K stated that they expected the Resident, who was assessed self-administering their medications, to be able to obtain their own medications. Staff K stated that they had a nurse who would be going to the ALF on 02/02/2024 to complete the form for the Family Assistance for Medication administration agreement for Resident 8.

In an email 02/02/2024 at 5:11 PM, Staff K sent a copy of a Family Assistance with Medications dated 02/02/2024 which were signed by Hospice and Resident 8. No family plan was provided for the family assistance provided prior to 02/02/2024.

Resident 12

Resident 12 was admitted on [redacted]/2023 with multiple diagnoses including [redacted].

Review of the Resident Evaluation and Negotiated Service Agreement (NSA) dated 09/27/2023 showed Resident 12 had a colostomy bag due to colostomy (an operation that creates an opening for the colon, or large intestine, through the abdomen). The NSA showed a third party or family managed the emptying and application of the bag.

On 12/11/2023 at 3:30 PM, Resident 12 stated that they moved into the ALF with their colostomy bag. Resident 12 stated that their husband and their daughter were the ones who would provide for the colostomy care including cleaning the ostomy site (is a surgery

to create an opening (stoma) from an area inside the body to the outside), emptying the bag and replacing the barrier (is the part of the appliance that goes against the skin and has a hole that fits around your stoma). Resident 12 stated that they call the staff because they needed help to care for the colostomy.

On 12/11/2023 at 4:05 PM, Staff K stated that there was no family assistance for the care of the colostomy. Staff K stated that they assumed the family and the resident would take care of the colostomy bag because they do not have nurse delegation, and no one was delegated. Staff K stated being not aware of an alternate plan agreement for the care of the colostomy bag.

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