STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Magnolia Operations LLC
Magnolia Care
1707 E Rowan Ave
Spokane, WA 99207

RE: Magnolia Care License # 2650

Dear Administrator:

This letter addresses Compliance Determination(s) 55366 (Completion Date 02/25/2025) and 53651 (Completion Date 01/23/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/25/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2850-1, WAC 388-78A-2850-1-a, WAC 388-78A-2850-1-b, WAC 388-78A-2850-1-b-i

The Department staff who did the off-site verification:
Veronica Jackson, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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

The department completed data collection for an unannounced on-site follow-up on 01/22/2025 and 01/23/2025 of:

Magnolia Care
1707 E Rowan Ave
Spokane, WA 99207

This document references the following SOD dated: 01/23/2025

The following sample was selected for review during the unannounced on-site visit: 6 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensor
Carla Rose, NCI Community Licensor
Jennifer Lee, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

J Salquist
Residential Care Services

02/03/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Brittney Beasley
Administrator (or Representative)

2/18/2025
Date

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as an assisted living facility;

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to notify construction review services before constructing two structures in 1 of 2 medication stations (Medication Station 1). This failure placed residents at risk of hazards related to structural supports constructed without department oversight.

Findings included...

Record review of the "Department of Social and Health Services" document, Statement of Deficiency completion date 12/12/2024, 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 as stated in the cited deficiencies in the enclosed report regarding WAC 388-78A-2850. 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 ALF is or will be in compliance with this law and/or regulation on 01/17/2025."

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

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-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as an assisted living facility;

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to notify construction review services before constructing two structures in 1 of 2 medication stations (Medication Station 1). This failure placed residents at risk of hazards related to structural supports constructed without department oversight.

Findings included…

Record review of the “Department of Social and Health Services” document, Statement of Deficiency completion date 12/12/2024, 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 as stated in the cited deficiencies in the enclosed report regarding WAC 388-78A-2850. 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 ALF is or will be in compliance with this law and/or regulation on 01/17/2025.”

Statement of Deficiencies	License #: 2650	Compliance Determination # 53651
Plan of Correction	Magnolia Care	Completion Date
Page 3 of 3	Licensee: Magnolia Operations LLC	01/23/2025

An observation on 01/22/2025 at 10:30 AM, showed two supportive structures in the nursing station on the enhanced adult residential care side of the building with beams approximately 8 inches high that span approximately 10 feet wide and were attached horizontally to the ceiling. These beams were supported by two wooden posts approximately 4 inches by 4 inches running vertical approximately 7 feet tall. Each vertical post was standing on a base of wood approximately 4 inches high and approximately 12 inches by 12 inches wide and long. The posts supporting beams were approximately 10 feet apart.

In an interview on 01/22/2025 at 10:50 AM, Staff A, Owner, stated they were unaware of the requirement to notify construction review services for their plan of correction for the statement of deficiency they received on 12/03/2024.

This is an uncorrected deficiency previously cited on 12/03/2024 for 388-78a-2850 (1)(a)(b)(i).

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) 2/21/25.

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

Administrator (or Representative) — Date: 2/18/2025

An observation on 01/22/2025 at 10:30 AM, showed two supportive structures in the nursing station on the enhanced adult residential care side of the building with beams approximately 8 inches high that span approximately 10 feet wide and were attached horizontally to the ceiling. These beams were supported by two wooden posts approximately 4 inches by 4 inches running vertical approximately 7 feet tall. Each vertical post was standing on a base of wood approximately 4 inches high and approximately 12 inches by 12 inches wide and long. The posts supporting beams were approximately 10 feet apart.

In an interview on 01/22/2025 at 10:50 AM, Staff A, Owner, stated they were unaware of the requirement to notify construction review services for their plan of correction for the statement of deficiency they received on 12/03/2024.

This is an uncorrected deficiency previously cited on 12/03/2024 for 388-78a-2850 (1)(a)(b)(i).

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, Magnolia Care 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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 2650	Compliance Determination #:50608
Plan of Correction:	Magnolia Care	Completion Date
Page 1 of 45	Licensee: Magnolia Operations LLC	12/03/2024

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 the unannounced on-site full inspection on 11/13/2024, 11/14/2024, 11/15/2024, 11/18/2024, 11/19/2024, 11/20/2024, 11/27/2024 and 11/29/2024 of:
Magnolia Care
1707 E Rowan Ave
Spokane, WA 99207

The following sample was selected for review during the unannounced on-site visit: 7 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensor
Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit 8
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

J Salquist
Residential Care Services

12/12/2024
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

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

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

The department completed data collection for the unannounced on-site full inspection on 11/13/2024, 11/14/2024, 11/15/2024, 11/18/2024, 11/19/2024, 11/20/2024, 11/27/2024 and 11/20/2024 of:
Magnolia Care
1707 E Rowan Ave
Spokane, WA 99207

The following sample was selected for review during the unannounced on-site visit: 7 of 42 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Veronica Jackson, Assisted Living Facility Licensor
Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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) 12/20/2024 Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were obtained in a timely manner for 3 of 7 residents (Resident 2, 5 and 7) sampled for medication services. This failed practice contributed to Residents 2 and 7 experiencing increased pain and decreased quality of life, and placed Residents 2, 5, and 7 at increased risk of health complications due to their missed doses of medications.

Findings included...

<Resident 5>

Review of Resident 5's undated face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 5's Negotiated Service Agreement (NSA) dated 10/07/2024 showed that Resident 5 required medication assistance from the facility.

Review of Resident 5's October 2024 and November 2024 Medication Administration Record (MAR) showed an order to give bupropion (a medication used to treat mental and mood disorders) twice daily starting on 10/22/2024. Further review showed that the medication was not administered because it was not available to give to the resident starting 10/22/2024 through 11/14/2024.

In an interview on 11/15/2024 at 2:37 PM, Staff M, Medication Technician (Med Tech), stated that the bupropion for Resident 5 was not available and that they have been out of the medication since it was ordered.

Administrator (or Representative) Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure prescribed medications were obtained in a timely manner for 3 of 7 residents (Resident 2, 5 and 7) sampled for medication services. This failed practice contributed to Residents 2 and 7 experiencing increased pain and decreased quality of life, and placed Residents 2, 5, and 7 at increased risk of health complications due to their missed doses of medications.

Findings included…

<Resident 5>

Review of Resident 5's undated face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 5's Negotiated Service Agreement (NSA) dated 10/07/2024 showed that Resident 5 required medication assistance from the facility.

Review of Resident 5's October 2024 and November 2024 Medication Administration Record (MAR) showed an order to give bupropion (a medication used to treat mental and mood disorders) twice daily starting on 10/22/2024. Further review showed that the medication was not administered because it was not available to give to the resident starting 10/22/2024 through 11/14/2024.

In an interview on 11/15/2024 at 2:37 PM, Staff M, Medication Technician (Med Tech), stated that the bupropion for Resident 5 was not available and that they have been out of the medication since it was ordered.

In an interview on 11/15/2024 at 3:51 PM, Staff A stated that they requested a new order for Resident' 5's bupropion prescription on 11/08/24 and that they were unaware that they were still out of the medication.

Review of Resident 5's October 2024 and November 2024 MAR showed orders to give hydroxyzine (a medication used to treat anxiety) twice daily. Further review showed that the medication was not administered because it was not available to give to the resident starting 10/28/2024 through 11/01/2024.

Review of Resident 5's October 2024 and November 2024 MAR showed orders to give melatonin (a medication used to improve sleep and treat depression) once daily. Further review showed that the medication was not administered because it was not available to give to the resident starting 10/30/2024 through 11/05/2024.

Review of Resident 5's October 2024 and November 2024 MAR showed orders to give paliperidone (a medication used to treat psychosis) once daily. Further review showed that the medication was not administered because it was not available to give to the resident starting 10/28/2024 through 10/31/2024.

Review of Resident 5's October 2024 and November 2024 MAR showed orders to give Trintellix (a medication used to treat depression) twice daily. Further review showed that the medication was not administered because it was not available to give to the resident on 11/07/2024 and 11/08/2024.

Review of Resident 5's October 2024 and November 2024 MAR showed orders to give benztropine (a medication used to treat schizoaffective disorder) twice daily. Further review showed that the 8:00 PM dose was not administered because it was not available to give to the resident on 11/12/2024.

In an interview on 11/18/2025 at 4:00 PM, Staff A stated that they reviewed the medications listed as "nonavailable" on the October 2024 and November 2024 MAR for Resident 5 and confirmed that they were all unavailable and had been documented correctly.

<Resident 7>

Review of Resident 7's NSA updated on 12/15/2023 showed the resident required medication assistance, had difficulty communicating, and required assistance with most activities of daily living related to having a stroke that caused left sided weakness. Further review showed the resident had a mood disorder that required a behavior intervention and crisis plan, and the resident had pain that required pain medication.

Review of Resident 7's MAR dated September 2024 showed orders for divalproex to be

given twice daily (used to stabilize mood and/or prevent seizures) and hydrocodone to be given three times daily (used to treat pain). Further review showed that these two medications were not given 09/24/2024 through 09/30/2024 and were marked as “unavailable”.

In an interview on 11/15/2024 at 2:20 PM, Resident 7, stated “yes” when asked if they had remembered going without their mood stabilizer and pain medication for multiple days in October. Resident 7 further stated “yes” when asked if they had increased pain and side effects from abruptly going without those medications.

In an interview on 11/15/2024 at 2:25 PM, Staff M, Med Tech, stated that Resident 7 did run out of pain and mood stabilizing medications for a period of multiple days in October 2024. Resident 7 further stated that the resident did complain of pain and was angrier and moodier during the days he was out of the medications.

<Resident 2>

Review of Resident 2’s NSA dated 05/31/2024 stated that staff were to oversee medication administration, document administration, and monitor and report any side effects.

Review of Resident 2’s MAR dated October 2024 and November 2024 showed an order to give diclofenac gel topically (applied to skin) to left knee four times a day. Further review showed it was not available to give to the resident on the following days: 10/21/2024, 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/01/2024, 11/02/2024, 11/03/2024, 11/05/2024, 11/06/2024, 11/07/2024, 11/08/2024, 11/09/2024, 11/10/2024, and 11/12/2024.

In an interview on 11/18/2024 at 11:15 AM, Resident 2, stated they had gone without their pain cream for their knees for a couple of weeks and they had increased pain especially at night.

In an interview on 11/18/2024 at 11:40 AM, Staff L, Med Tech, stated that Resident 2 had been out of their pain cream for a week or two and they were unable to administer it.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beyer 12/20/2024

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 observation, interview and record review, the facility failed to ensure that the facilities medication systems supported current medication orders accurately and residents received medication as prescribed for 4 of 7 residents (Resident 2, 3, 5 and 6). This failed practice resulted in Resident 2, 3, and 5 not getting their medication as prescribed due to transcription errors when changing pharmacies, and inaccurate medication administration documentation for Resident 2, 3, 5 and 6, and placed residents at risk of serious health complications.

Findings included...

Review of the undated facility policy "Medication Documentation Policy for Assisted Living Facilities in Washington State" showed that staff "must utilize a MAR [Medication Administration Record] to document all prescribed medications, over-the-counter drugs, and PRN (as-needed) medications." The policy showed that all medications must be documented immediately after administration.

In an interview on 11/15/2024 at 3:15 PM, Staff A, Administrator, stated they switched pharmacies on 10/01/2024 due to issues with the previous pharmacy.

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, Magnolia Care 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:

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(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 observation, interview and record review, the facility failed to ensure that the facilities medication systems supported current medication orders accurately and residents received medication as prescribed for 4 of 7 residents (Resident 2, 3, 5 and 6). This failed practice resulted in Resident 2, 3, and 5 not getting their medication as prescribed due to transcription errors when changing pharmacies, and inaccurate medication administration documentation for Resident 2, 3, 5 and 6, and placed residents at risk of serious health complications.

Findings included...

Review of the undated facility policy “Medication Documentation Policy for Assisted Living Facilities in Washington State” showed that staff “must utilize a MAR [Medication Administration Record] to document all prescribed medications, over-the-counter drugs, and PRN (as-needed) medications.” The policy showed that all medications must be documented immediately after administration.

In an interview on 11/15/2024 at 3:15 PM, Staff A, Administrator, stated they switched pharmacies on 10/01/2024 due to issues with the previous pharmacy.

Review of the facility's September 2024 and October 2024 MAR showed that the facility used Quick MAR (an electronic medical management system) to document medication administration through 10/14/2024. Review of the facility's October 2024 and November 2024 MAR showed that the facility switched to Bluestep (an electronic medical management system) to document medication administration beginning 10/15/2024.

In an interview on 11/18/2025 at 4:00 PM, Staff A stated that they did not audit the MAR following the transition to the new system to ensure all medications were transferred. Staff A further stated that staff notified Staff I, Registered Nurse, when noticed an error in the new system and Staff I fixed them. Staff A confirmed they relied on staff to catch errors and problems and report them. Staff A further stated that the last medication audit was conducted at the beginning of summer 2024 by Staff A and Staff K, Administrative Assistant, but that they do not have any record or documentation of the audit.

In an interview on 11/27/2024 at 10:10 AM, Staff C, Medication Technician (Med Tech), stated that there was a list of medications that were not entered into the new medication system that was provided to Staff I. Staff C identified one medication on the list that continued to be administered that had not yet been added to the new medication system. Staff C further stated that they did not have documentation confirming when it was administered because there was still nowhere to document it.

In an interview on 11/27/2024 at 11:23 AM, Staff M, Med Tech, stated that there were several medications that were missing in the new system after the transition. Staff M stated that they communicated with Staff I each time a medication was found to be missing and that Staff I would update the system. Staff M stated some medications were updated immediately while other medications took up to a week to be added. Staff M further stated that they continued to administer the medications while updates were made but were unable to document the medications once administered because there was nowhere to document it.

<Resident 3>

Review of Resident 3's face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 3's NSA dated 10/27/2024 showed that Resident 3 required medication assistance from the facility.

Review of Resident 3's Comprehensive Assessment Reporting Evaluation (CARE's) assessment dated 11/01/2024 showed that Resident 3's limitations regarding medications included "cannot open containers, does not record blood sugars, does not follow frequency or dosage, forgets to take medications."

Resident 3 Medication Errors - Entresto

Review of an After Visit Summary for Resident 3 dated 09/19/2024 showed instructions to stop taking Entresto (a medication used to treat chronic heart failure) due to worsening kidney function.

Review of Resident 3's September 2024 and October 2024 MAR showed an order for Entresto to be given twice a day. Further review showed the final recorded dose was administered on 10/14/2024 and that 41 doses of the medication were administered to Resident 3 after the medication was discontinued on 09/19/2024.

Resident 3 Medication Errors – lantus/basaglar

Review of Resident 3's September 2024 and October 2024 MAR showed that Resident 3 had an order for Basaglar Kwikpen (a slow-acting insulin) for 25 units injected every morning. Review showed the order listed on the MAR when recorded in the QuickMAR system. Further review of the October 2024 MAR after the transition to the Bluestep system showed an order for Lantus (an alternative slow-acting insulin) with an end date of 10/17/2024 and did not show an order for Basaglar.

In an interview on 11/26/2024 at 9:17 AM, Staff I, stated that they had discontinued the Lantus on the MAR and would locate the order discontinuing the medication to provide to the department.

In an interview on 11/27/2024 at 10:10 AM, Staff C, Med Tech, stated that they do not have any Lantus and continued to administer the Basaglar to Resident 3. Staff C further stated that they are not able to record the medication when administered because it is not listed on the MAR and there is nowhere else to record it. Staff C was unable to confirm what dates the Basaglar had been administered to Resident 3. Staff C stated that the Basaglar is probably on the list of medications that still need to be entered into the new MAR system. Staff C presented the department with the Basaglar box and pen that they are currently administering to Resident 3.

Observation of the Basaglar box and a single injection pen for Resident 3 showed a fill date of 08/19/2024. The prescription on the box indicated that 25 units are to be injected daily. Further observation of the box showed that each individual pen contained a total of 100 units (4 doses per pen) and that the box came with a total of 5 pens (20 doses per box). There were insufficient insulin doses to administer the medication between 09/01/2024 and 11/29/2024.

Review of an email dated 11/29/2024 from Staff A to the department, showed that Staff A spoke with the provider who confirmed that Resident 3 should be receiving Lantus for their slow-acting insulin and that the medication was not discontinued. Further review showed that Staff A indicated the medication should not have been removed from the MAR and that the error was not caught until the inspection by the department.

Resident 3 Transcription Errors

Review of Resident 3's September 2024, October 2024, and November 2024 MAR showed that 48 doses of the following medications were not documented as administered (entry was left blank) with no reason or explanation provided:

Aspirin (a medication used to lower the risk of heart attack and stroke): 10/13/2024, 10/14/2024

Atorvastatin (a medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, strokes, and heart attacks): 09/06/2024,10/16/2024,10/22/2024, 11/05/2024

Basaglar Kwikpen (a long-acting insulin used to treat diabetes): 10/13/2024

Carvedilol (a medication used to treat heart failure and high blood pressure): 09/06/2024 (1 of 2 doses), 10/23/204 (2 of 2 doses), 10/16/2024 (1 of 2 doses), 10/22/2024 (1 of 2 doses)

Entresto (a medication used to treat chronic heart failure): 09/06/2024 (1 of 2 doses)

Gabapentin (a medication used to prevent and control partial seizures and treat neuropathic pain): 10/05/2024 (1 of 2 doses), 10/11/2024 (1 of 2 doses), 10/12/2024 (1 of 2 doses), 10/13/24 (2 of 2 doses), 10/22/2024 (1 of 2 doses), 11/05/2024 (1 of 2 doses)

Humalog/Lispro (fast-acting insulin): 09/01/2024 (1 of 4 doses), 09/02/2024 (1 of 4 doses), 09/06/2024 (1 of 4 doses), 10/05/2024 (3 of 4 doses),10/06/2024 (1 of 4 doses), 10/11/2024 (2 of 4 doses), 10/12/2024 (3 of 4 doses), 10/13/2024 (2 of 4 doses), 10/14/2024 (2 of 4 doses), 10/15/2024 (1 of 4 doses), 10/16/2024 (2 of 4 doses), 10/22/2024 (2 of 4 doses), 11/05/2025 (1 of 4 doses)

Isosorb Mono (a medication used to dilate blood vessels and increase the supply of blood and oxygen to the heart): 10/12/2024, 10/13/2024

Magnesium Oxide (a supplement): 10/12/2024, 10/13/2024

Senna-Time (used to treat constipation): 10/05/2024, 10/11/2024

In an interview on 11/15/2024 at 10:32 AM, Staff C stated that blank entries on the MAR are referred to as “missed MARs” and that the system notified administration when they occur.

<Resident 5>

Review of Resident 5’s undated face sheet showed diagnoses of [redacted] and [redacted]

Review of Resident 5’s NSA dated 10/07/2024 showed that Resident 3 required medication assistance from the facility.

Review of Resident 5’s October 2024 and November 2024 MAR showed that the resident was prescribed buproprion (a medication used to treat depression. Further review of the MAR showed the buproprion was documented as “administered” on 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, 11/02/2024, and 11/12/2024, and “refused” on 10/28/2024.

In an interview on 11/15/2024 at 2:37 PM, Staff M, Medical Technician, stated that the bupropion for Resident 5 was not available and that they have been out of the medication since it was ordered.

In an interview on 11/18/2025 at 4:00 PM, Staff A, Administrator, stated that the buproprion had arrived from the pharmacy.

Review of Resident 5’s October 2024 and November 2024 MAR showed that the resident was prescribed melatonin (a medication used to improve sleep and treat depression). Further review showed that the melatonin was not available to give to the resident starting 10/30/2024 through 11/05/2024 and that the melatonin was documented as “administered” on 11/02/2024.

In an interview on 11/18/2025 at 4:00 PM, Staff A stated that the buproprion and

melatonin had not been administered or refused on the dates noted above and identified the chartings as documentation errors. Staff A stated the medications had not been available for administration on those dates.

<Resident 6>

Review of Resident 6's undated face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 6's NSA dated 03/15/2024 showed that staff is to oversee medication administration.

Review of Resident 6's October 2024, and November 2024 MAR showed an order for Vitamin D3 with instructions to take 1 capsule by mouth once a month. Further review showed that the medication was initialed as administered on 10/12/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/18/2024, 10/19/2024, 10/20/2024, 10/21/2024, 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/26/2024, 10/27/2024, 10/28/2024, 10/29/2024, 10/30/2024, 10/31/2024, 11/01/2024, 11/02/2024, 11/03/2024, 11/04/2024, 11/05/2024, 11/06/2024, 11/08/2024, 11/09/2024, 11/10/2024, 11/12/2024, and 11/13/2024.

In an interview on 11/18/2024 at 2:30 PM, Staff M, Med Tech, stated that the Vitamin D3 was entered into the MAR incorrectly following the transition to the new electronic medical management system and that it is only to be given to Resident 6 on the 1st of every month. Staff M further stated that they have notified Staff I, of the error on multiple occasions but that the system had not yet been updated. They confirmed that they have initialed the medication every day because the system does not currently recognize that it was only to be given once a month. Staff M confirmed that that the medication was only administered on the first day of the month. Staff M showed the department the December 2024 blister pack containing the Vitamin D3 and stated that it was packed in the same manner on previous months.

Observation on 11/18/2024 at 2:30 PM, showed a blister pack for the Vitamin D3 which contained a single pill on the 1st of the month and empty blisters for the remaining days of the month.

In an interview on 11/18/2024 at 4:00 PM, Staff A stated that the Vitamin D3 was entered incorrectly into the MAR. Staff A confirmed that they were aware that staff were signing off on the medication on a daily basis and identified the chartings on days other

than the first of the month as documentation errors.

<Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA) dated 05/31/2024 stated that staff were to oversee medication administration, document administration and monitor and report any side effects. Further review showed that Resident 2 required blood sugar (BS) checks and received long-acting insulin.

Review of Resident 2's MAR dated September 2024, October 2024 and November 2024 showed an order to give Lantus (long-acting insulin used to lower blood sugar) daily in the morning, and to raise the dose by 2 units if the resident's blood sugar was over 200. Further review showed that when the previously used medication documentation program stopped being used in the middle of October 2024 a duplicate order for the long-acting insulin appeared. Further review showed that staff had signed off that they had administered the insulin dose twice at the same time every am from 10/15/2024-11/13/2024. Further review showed that the long-acting insulin was held on 11/03/2024 with reason codes as "2 wrong size gauges" on one order and on the duplicate order, the code stated "3 couldn't check blood sugar". Review showed there was no order to hold the resident's long-acting insulin.

In an interview on 11/18/2024 at 11:03 AM, Resident 2, stated that their long-acting insulin was held recently in November because staff were not able to check their blood sugar.

In an interview on 11/18/2024 at 3:05 PM, Staff I, Registered Nurse, stated the duplicate insulin order was an error.

Plan/Attestation Statement

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

than the first of the month as documentation errors.

<Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA) dated 05/31/2024 stated that staff were to oversee medication administration, document administration and monitor and report any side effects. Further review showed that Resident 2 required blood sugar (BS) checks and received long-acting insulin.

Review of Resident 2's MAR dated September 2024, October 2024 and November 2024 showed an order to give Lantus (long-acting insulin used to lower blood sugar) daily in the morning, and to raise the dose by 2 units if the resident's blood sugar was over 200. Further review showed that when the previously used medication documentation program stopped being used in the middle of October 2024 a duplicate order for the long-acting insulin appeared. Further review showed that staff had signed off that they had administered the insulin dose twice at the same time every am from 10/15/2024-11/13/2024. Further review showed that the long-acting insulin was held on 11/09/2024 with reason codes as "2 wrong size gauges" on one order and on the duplicate order, the code stated "3 couldn't check blood sugar". Review showed there was no order to hold the resident's long-acting insulin.

In an interview on 11/18/2024 at 11:03 AM, Resident 2, stated that their long-acting insulin was held recently in November because staff were not able to check their blood sugar.

In an interview on 11/18/2024 at 3:05 PM, Staff I, Registered Nurse, stated the duplicate insulin order was an error.

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Administrator (or Representative) 12/20/2024 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.

(5) When a resident authorizes the release of health care information or resident authorization is not required under RCW 70.02.050 , the assisted living facility must contact the external health care provider and coordinate services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate with health care providers and set requested appointments for 2 of 7 residents (Resident 3 and 6). This failure resulted in a delay in evaluation and care and placed residents at risk of serious health complications.

<Resident 3>

Review of Resident 3's face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 3's Negotiated Service Agreement (NSA) dated 10/27/2024, showed that staff would "assist in making/receiving calls regarding care."

Review of an After Visit Summary dated [redacted]2024 showed that Resident 3 was hospitalized at Holy Family Hospital from [redacted]2024 – [redacted]2024 due to a hypertensive (high blood pressure) emergency. Further review showed instructions to schedule an appointment with Providence Kidney Care as soon as possible for a visit and that a referral had been sent by the hospital.

Review of Resident 3's November 2024 nurse's notes showed no documentation of a scheduled appointment.

In an interview on 11/15/2024 at 3:15 PM Staff A, Administrator, stated that they review any hospital records or discharge orders for residents when they return. In an interview on 11/18/2024 at 10:01 AM, Staff A, Administrator, stated that they had not yet made an appointment for Resident 3 with Providence Kidney Care.

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.

(5) When a resident authorizes the release of health care information or resident authorization is not required under RCW 70.02.050 , the assisted living facility must contact the external health care provider and coordinate services.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to coordinate with health care providers and set requested appointments for 2 of 7 residents (Resident 3 and 6). This failure resulted in a delay in evaluation and care and placed residents at risk of serious health complications.

<Resident 3>

Review of Resident 3's face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 3's Negotiated Service Agreement (NSA) dated 10/27/2024, showed that staff would "assist in making/receiving calls regarding care."

Review of an After Visit Summary dated [redacted]/2024 showed that Resident 3 was hospitalized at Holy Family Hospital from [redacted]/2024 – [redacted]/2024 due to a hypertensive (high blood pressure) emergency. Further review showed instructions to schedule an appointment with Providence Kidney Care as soon as possible for a visit and that a referral had been sent by the hospital.

Review of Resident 3's November 2024 nurse's notes showed no documentation of a scheduled appointment.

In an interview on 11/15/2024 at 3:15 PM Staff A, Administrator, stated that they review any hospital records or discharge orders for residents when they return. In an interview on 11/18/2024 at 10:01 AM, Staff A, Administrator, stated that they had not yet made an appointment for Resident 3 with Providence Kidney Care.

In an interview on 11/18/2024 at 12:36 PM, Staff J, Scheduler, stated that they were just told about Resident 3's kidney appointment that day and that it had since been scheduled. When asked how staff let them know an appointment needs to be scheduled, they stated they collect paperwork from residents when they return from the hospital if they are on site. They stated they also receive verbal requests from staff and requests on post-it notes on their desk.

<Resident 6>

Review of Resident 6's undated face sheet showed diagnoses of [redacted] and [redacted]

Review of Resident 6's NSA dated 03/15/2024 showed that staff will "manage calls regarding care."

Review of Resident 6's Nurse's Note dated 09/12/2024 showed that the primary care provider (PCP) came in for their rounds on 09/12/2024 and wrote a referral to Inland Imaging. Review further showed that Staff J "is setting up an appointment so that [Resident 6] can get further checked." The note was signed by Staff K, Administrative Assistant.

Review of a document titled "Referral" at the top and dated 09/18/2024 showed the document contained patient, insurance, and referral information. Further review showed a section labeled "Referral To Information" on the bottom of the form, with "Provider Name: Inland Imaging Spokane" directly underneath.

In an interview on 11/28/2024 at 12:36 PM, Staff J stated they had not scheduled an appointment with Inland Imaging for Resident 6. Staff J further stated that they were not aware that an appointment needed to be scheduled.

In an interview with 11/18/2024 at 3:00 PM, Staff K confirmed they assist with visits by the PCP when they come to the facility to meet with residents. Staff K further confirmed that they wrote the Nurse's Note on 09/12/2024 regarding Resident 6. They stated that when the PCP conducts visits at the facility, they provide a verbal update following the visit and then fax paperwork outlining any changes, orders, or appointments the following day. Staff K stated that they provide the scheduler with a copy of the faxed

paperwork from the PCP to request that an appointment be scheduled. Staff K stated that the Nurse's Note that they wrote on 09/12/2024 should have read "[Staff J] will be setting up an appointment."

In an interview on 11/18/2024 at 4:00 PM Staff A stated that they have communicated appointments that required scheduling to Staff J by providing a copy of the PCP's paperwork, verbally, or on a post-it note left on their desk. Staff A confirmed there is no consistent process they utilize to communicate appointments to Staff J.

In an interview on 11/18/2024 at 9:44 AM, Staff J stated that they did not receive the referral sheet provided to the department. They confirmed there is no consistent process staff utilize to communicate appointment requests.

Plan/Attestation Statement

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

Brittney Beg — 12/20/2024

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.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and

paperwork from the PCP to request that an appointment be scheduled. Staff K stated that the Nurse's Note that they wrote on 09/12/2024 should have read "[Staff J] will be setting up an appointment."

In an interview on 11/18/2024 at 4:00 PM Staff A stated that they have communicated appointments that required scheduling to Staff J by providing a copy of the PCP's paperwork, verbally, or on a post-it note left on their desk. Staff A confirmed there is no consistent process they utilize to communicate appointments to Staff J.

In an interview on 11/19/2024 at 9:44 AM, Staff J stated that they did not receive the referral sheet provided to the department. They confirmed there is no consistent process staff utilize to communicate appointment requests.

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.

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and

accurately direct others to administer to him/her;

(b) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to self-administer when he/she has the assistance of a caregiver; and

(c) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is not able to self-administer, and needs to have administered to him or her.

(3) The individual's nursing needs when the individual requires the services of a nurse on the assisted living facility premises.

(4) Individual's sensory abilities, including:

(a) Vision; and

(b) Hearing.

(5) Individual's communication abilities, including:

(a) Modes of expression;

(b) Ability to make self understood; and

(c) Ability to understand others.

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

(a) History of substance abuse;

(b) History of harming self, others, or property; or

(c) Other conditions that may require behavioral intervention strategies;

(d) Individual's ability to leave the assisted living facility unsupervised; and

(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.

(7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of:

(a) Mental illness, or needs for psychological or mental health services, except where protected by confidentiality laws;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the assisted living facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury.

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

(a) Ability to perform activities of daily living;

(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.

(10) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(11) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive, or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker; and

(c) The scope of decision-making authority of any substitute decision maker.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a full assessment within 14 days of admission for 2 of 7 residents (Resident 2 and 5). This failure placed residents at risk of not receiving care that supported or aligned with their current needs.

Findings included…

In an interview on 11/13/2024 at 3:26 PM, Staff G, Medication Technician Supervisor, stated that the residents usually come with their own assessments and that the facility only writes care plans.

In an interview on 11/14/204 at 10:15 PM, Staff A, Administrator, stated that the state case manager wrote the residents' assessments. Staff A further stated that the facility does not write their own assessments.

Review of Resident 2's undated medical file showed a move-in date of [redacted]/2024 and a Comprehensive Assessment Reporting Evaluation (CARE's) assessment completed by

Resident 2's case manager on 03/04/2024 before Resident 2 was admitted to the facility. Further review showed no documentation of an assessment completed by the facility.

Review of Resident 5's undated medical file showed a move-in date of [redacted]2024. Further review showed no documentation of an assessment completed by the facility.

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Brittney Beg — 12/20/2024

Administrator (or Representative) — Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually.

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to complete annual and ongoing assessments including safety and smoking for 5 of 7 sampled residents (Resident 1, 3, 4, 6 and 7). This failure resulted in Resident 1 and 3 not having a safety assessment for smoking and Resident 7 not having a safety assessment for the use of a transfer pole. This failed practice placed the residents at risk of not receiving care based on current assessed needs and at risk of injury during smoking and potential falls while using a medical device.

Findings included...

<Annual Assessments>

In an interview on 11/14/204 at 10:15 PM, Staff A, Administrator, stated that the state case manager wrote the residents' assessments. Staff A further stated that the facility does not write their own assessments.

Resident 2's case manager on 03/04/2024 before Resident 2 was admitted to the facility. Further review showed no documentation of an assessment completed by the facility.

Review of Resident 5's undated medical file showed a move-in date of [redacted]/2024. Further review showed no documentation of an assessment completed by the facility.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to complete annual and ongoing assessments including safety and smoking for 5 of 7 sampled residents (Resident 1, 3, 4, 6 and 7). This failure resulted in Resident 1 and 3 not having a safety assessment for smoking and Resident 7 not having a safety assessment for the use of a transfer pole. This failed practice placed the residents at risk of not receiving care based on current assessed needs and at risk of injury during smoking and potential falls while using a medical device.

Findings included…

<Annual Assessments>

In an interview on 11/14/204 at 10:15 PM, Staff A, Administrator, stated that the state case manager wrote the residents' assessments. Staff A further stated that the facility does not write their own assessments.

In an interview on 11/13/2024 at 3:26 PM, Staff G, Medication Technician Supervisor, stated that the residents usually come with their own assessment and that the facility only writes care plans.

Review of Resident 1's undated medical file showed a move-in date of [redacted]/2022. Further review showed no documentation of an annual assessment completed by the facility.

Review of Resident 3's undated medical file showed a move-in date of [redacted]/2022. Further review showed no documentation of an annual assessment completed by the facility.

Review of Resident 4's undated medical file showed a move-in date of [redacted]/2023. Further review showed no documentation of an annual assessment completed by the facility.

Review of Resident 6's undated medical file showed a move-in date of [redacted]/2018. Further review showed no documentation of an annual assessment completed by the facility.

Review of Resident 7's undated medical file showed a move-in date of [redacted]/2012. Further review showed no documentation of an annual assessment completed by the facility.

<Smoking Assessments>

Review of the facility's undated characteristics roster identified Resident 1 and Resident 3 as smokers.

In an interview on 11/14/2024 at 10:45AM, Staff A, stated that they only completed smoking assessments for residents that require supervised smoking and that they do not have smoking assessments for Resident 1 and 3.

Review of Resident 1's records did not show any safety assessment for smoking for Resident 1 since admission on [redacted]/2022.

An observation on 11/14/2024 at 1:15 PM, showed Resident 1 using continuous oxygen at 2 liters per minute using an open face mask, hooked up to an oxygen concentrator. Resident 1 stated that they did smoke cigarettes during the interview.

Review of Resident 1's records did not show any safety assessment for smoking for

Resident 3 since admission on [redacted] 2022.

An observation on 11/14/2024 at 1:28 PM showed Resident 3 rolling multiple cigarettes in their room. Resident 3 confirmed they roll their own cigarettes during the interview.

<Medical Device Assessment>

Review of the facility's undated characteristics roster identified Resident 7 as having a medical device.

Review of Resident 7's Negotiated Service Agreement last updated on 12/15/2023 showed the resident used a bar to assist with transfers at bedside and had a history of falls.

An observation on 11/15/2024 at 2:20 PM, during Resident 7's interview, showed that their room had a transfer pole next to their bed that spanned from floor to ceiling. When asked, Resident 7 stated "yes" that they do use the pole to transfer from bed to wheelchair and wheelchair to their bed.

Review of Resident 7's records as of 11/18/2024, showed no assessment was completed for the use of a transfer pole.

In an interview on 11/18/2024 at 10:10 AM Staff A, stated that Resident 7 had not had a safety assessment completed for use of their transfer pole at their bedside.

This is a recurring deficiency previously cited on 03/25/2024 for subsections (2)(a).

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Brittney Beg

Administrator (or Representative)

12/20/2024

Date

Resident 3 since admission on [redacted]/2022.

An observation on 11/14/2024 at 1:28 PM showed Resident 3 rolling multiple cigarettes in their room. Resident 3 confirmed they roll their own cigarettes during the interview.

<Medical Device Assessment>

Review of the facility's undated characteristics roster identified Resident 7 as having a medical device.

Review of Resident 7's Negotiated Service Agreement last updated on 12/15/2023 showed the resident used a bar to assist with transfers at bedside and had a history of falls.

An observation on 11/15/2024 at 2:20 PM, during Resident 7's interview, showed that their room had a transfer pole next to their bed that spanned from floor to ceiling. When asked, Resident 7 stated "yes" that they do use the pole to transfer from bed to wheelchair and wheelchair to their bed.

Review of Resident 7's records as of 11/18/2024, showed no assessment was completed for the use of a transfer pole.

In an interview on 11/18/2024 at 10:10 AM Staff A, stated that Resident 7 had not had a safety assessment completed for use of their transfer pole at their bedside.

This is a recurring deficiency previously cited on 03/25/2024 for subsections (2)(a).

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on observation, interview and record review the facility failed to update negotiated service agreements when they no longer reflected current needs for 3 of 7 sampled residents. (Residents 1, 2, and 6). This failed practice placed the residents at risk of health complications related to not receiving care that they required.

Findings included...

<Resident 1>

Oxygen therapy

Review of Resident 1’s Negotiated Service Agreement (NSA) last updated on 01/18/2024, did not show that the resident required oxygen therapy, why they required oxygen, their recent recurrent hospitalizations for acute respiratory failure, what equipment the resident was using, how often the equipment should be monitored, what to do if it wasn’t working appropriately or who to contact for replacement, how much oxygen was ordered or how often to check resident’s blood oxygen level with a pulse oximeter (this level is taken by a machine that clips onto a finger to test the blood oxygen/hemoglobin level that indicates if supplemental oxygen is sufficient or needs to be adjusted), who should replace the equipment tubing and supplies, how often supplies should be replaced for infection control prevention, what precautions to take when the resident smokes, what interventions may be required after the resident smokes and has difficulty breathing, or indications of when to notify the facility nurse or the resident’s primary care physician.

An observation on 11/14/2024 at 1:15 PM, during Resident 1’s interview showed that they were wearing an open oxygen face mask and were receiving oxygen from an oxygen concentrator at 2 liters per minute continuously.

Review of Resident 1’s facility’s nursing notes for October 2024 and November 2024 showed that on:

[redacted]/2024: The resident experienced low blood oxygen level of 74 and was having trouble breathing, and that they were sent to the hospital by ambulance.
[redacted]/2024: The resident came home from the hospital with oxygen and a couple of new medications.
11/11/2024: The resident had gone out again to the hospital, same as last month and has an appointment to see cardiology department in December.

Review of Resident 1's hospital records physician progress note dated 11/07/2024 showed the resident's admission was preceded by reported issues with the valve on their transportable oxygen and that they had been off of their normal oxygen supplementation the week prior.

In an interview on 11/14/2024 at 2:00 PM, Staff C, Medication Technician (Med Tech) stated they do not check Resident 1's oxygen level because there were no instructions for monitoring Resident 1's oxygen.

In an interview on 11/14/2024 at 2:20 PM, Staff G, Med Tech Supervisor, stated that Resident 1 had not been placed on any alert charting for monitoring purposes on return from the hospital in [redacted] 2024 and [redacted] 2024, and did not have a temporary care plan initiated after either hospital stay. Staff G stated that the resident's vital signs were taken monthly and did not include a pulse oximeter reading to check for blood oxygen levels even after the resident required continuous oxygen after returning from the hospital on [redacted]/2024.

<Resident 2>

Review of Resident 2's NSA dated 05/31/2024 showed the resident had a Dexcom 6 continuous glucometer (a device used to measure blood sugar) that notified them when their blood sugar is too high or too low and takes a long-acting insulin. The plan did not show who administers the insulin, what supplies were needed for the Dexcom 6, what interventions would be required for low and high blood sugars, who to notify if blood sugars are high or low, or how often to reorder supplies. Review showed that Resident 2 used pain patches that were used to treat their chronic pain. Further review showed that the NSA did not include where the pain was, who applied the patches, what medication was in the patches or how often they were required to be replaced.

In an interview at 11/18/2024 at 11:05 AM Resident 2 was asked about an incident that was noted in the nursing notes that indicated that medication services were not delivered to residents in their rooms at the facility. Resident 2 stated that they had diabetic neuropathy in their feet that caused severe pain that effected their mobility with their walker. Further review of Resident 2's NSA showed no location of the resident's pain, what to do for the resident when they were unable to ambulate with their walker due to severe foot pain, or how to provide medication services when they were unable to leave their room.

In an interview on 11/18/2024 at 11:40 am, Staff L, Med Tech, confirmed that they do not take Resident 2's medication to them and that Resident 2 must come to the med cart.

<Resident 6>

Review of Resident 6's undated face sheet showed diagnoses of [redacted] and [redacted]

Resident 6 Falls

Review of Resident 6's NSA dated 03/15/2024 showed that Resident 6 walks independently without any assistive devices in their room and immediate living environment, and only requires assistance outside of the immediate living environment. Further review showed that staff are to "report any concerns regarding mobility to administration" with no information or interventions regarding falls or fall risk.

Review of Resident 6's Nurse's Notes showed notes on 07/15/2024, 10/28/2024, and 11/07/2024 that indicated that Resident 6 had fallen. Further review showed that the note on 07/15/2024 read that Resident 6 "had once again fallen in [their] room."

In an interview on 11/19/2024 at 10:43 AM, Resident 6 stated that they have fallen in their apartment several times and that they do not know why. Resident 6 stated that they remember walking and then being on the floor. They stated they land on their knees. Resident 6 further stated that they do not tell staff every time they fall. They stated that the last time they fell down they were unable to stand up and that the only way they could see to get out the door was to go out into the hallway on their bottom. Resident 6 stated that they do not like falling and that "it is scary."

In an interview on 11/19/2024 at 10:07 AM, Staff H, Caregiver, stated that Resident 6 had fallen in their room on several occasions. They stated that Resident 6 had a history of falling prior to their note on 07/15/2024 and that they documented the prior falls in the nurse's notes. When asked if they completed an incident report following any of the falls, Staff H stated they do not believe so but that they may have filled one out for the fall on 11/07/24.

Resident 6 Urinary Retention

Review of Resident 6's NSA dated 03/15/2024 showed that Resident 6 is independent with toileting, wears briefs, and manages their own changing and pericare. Further review showed that Resident 6 "retains urine and at times gets to the point where [they] no longer urinate." Review showed that Resident 6 had a catheter placed several times but does not currently have a catheter due to a history of pulling it out or cutting it. Review showed that Urology recommended self-catheterization (inserting a single-use catheter to drain your urine at regular intervals throughout the day) but that Resident 6 refused to learn how to do it. The NSA instructs staff to monitor Resident 6 for urine retention but does not include what to monitor for or signs, symptoms, or indications of urine retention. The NSA also instructs staff to report any concerns regarding toileting to the provider and administration but does provide information about how Resident 6's urine retention may present or means to track whether Resident 6 is urinating on a regular basis.

In an interview on 11/15/2024 at 3:01 PM, Staff M, Med Tech, stated that Resident 6 no longer has a catheter and that it was removed because Resident 6 kept taking it out.

This is a recurring deficiency previously cited on 03/25/2024 for subsections (3)(b).

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beyer — 12/20/2024

Administrator (Or Representative) — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person:

Resident 6 Urinary Retention

Review of Resident 6's NSA dated 03/15/2024 showed that Resident 6 is independent with toileting, wears briefs, and manages their own changing and pericare. Further review showed that Resident 6 "retains urine and at times gets to the point where [they] no longer urinate." Review showed that Resident 6 had a catheter placed several times but does not currently have a catheter due to a history of pulling it out or cutting it. Review showed that Urology recommended self-catheterization (inserting a single-use catheter to drain your urine at regular intervals throughout the day) but that Resident 6 refused to learn how to do it. The NSA instructs staff to monitor Resident 6 for urine retention but does not include what to monitor for or signs, symptoms, or indications of urine retention. The NSA also instructs staff to report any concerns regarding toileting to the provider and administration but does provide information about how Resident 6's urine retention may present or means to track whether Resident 6 is urinating on a regular basis.

In an interview on 11/15/2024 at 3:01 PM, Staff M, Med Tech, stated that Resident 6 no longer has a catheter and that it was removed because Resident 6 kept taking it out.

This is a recurring deficiency previously cited on 03/25/2024 for subsections (3)(b).

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-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the prescribing provider when a resident refused their medication for 1 of 7 residents (Resident 3). This failure resulted in the provider being unaware that the resident was not receiving their medication as prescribed and placed the resident at risk of serious health complications.

Findings included...

Review of the undated facility policy "Medication Documentation Policy for Assisted Living Facilities in Washington State" showed that the prescribing provider should be notified if the missed or refused dose poses a risk to the resident's health.

Review of Resident 3's face sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 3's Negotiated Service Agreement (NSA) dated 10/27/2024 showed that Resident 3 required medication assistance from the facility and that they "will sometimes be resistive to medications."

Review of Resident 3's September 2024, October 2024, and November 2024 Medication Administration Record showed that 49 doses of the following medications were not administered due to refusal:

Aspirin (a medication used to lower the risk of heart attack and stroke): 09/06/2024, 09/07/2024, 09/22/2024

Atorvastatin (a medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, strokes, and heart attacks): 09/09/2024, 10/13/2024

Basaglar Kwikpen (a long-acting insulin used to treat diabetes): 09/06/2024, 09/07/2024, 09/22/2024

Carvedilol (a medication used to treat heart failure and high blood pressure): 09/06/2024, 09/07/2024, 09/09/2024, 09/22/2024, 11/08/2024

Entresto (a medication used to treat chronic heart failure): 09/06/2024, 09/07/2024, 09/09/2024, 09/22/2024

Furosemide (a medication used to help rid the body of extra water): 09/06/2024, 09/07/2024, 09/22/2024

Gabapentin (a medication used to prevent and control partial seizures and treat neuropathic pain): 09/01/2024 (1 of 3 doses), 09/06/2024 (2 of 3 doses), 09/07/2024 (1 of 3 doses), 09/09/2024 (1 of 3 doses), 09/22/2024 (2 of 3 doses)

Humalog/Lispro (fast-acting insulin): 09/01/2024 (2 of 4 doses), 09/06/2024 (2 of 4 doses), 09/07/2024 (1 of 4 doses), 09/09/2024 (2 of 4 doses), 09/22/2024 (2 of 4 doses), 10/13/2024 (1 of 4 doses), 11/08/2024 (1 of 4 doses), 11/09/2024 (1 of 4 doses), 11/10/2024 (1 of 4 doses), 11/11/2024 (2 of 4 doses)

Isosorb mono (a medication used to dilate blood vessels): 09/22/2024

Magnesium Oxide (a supplement): 09/06/2024, 09/07/2024, 09/22/2024

Potassium (a supplement): 09/06/2024, 09/07/2024, 09/22/2024

In an interview on 11/18/2024 at 10:01 AM, Staff A stated that they have not informed Resident 3's prescribing provider about the number and frequency of Resident 3's missed medications due to refusal.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beg — 12/20/2024

Administrator (or Representative) — Date

Carvedilol (a medication used to treat heart failure and high blood pressure): 09/06/2024, 09/07/2024, 09/09/2024, 09/22/2024, 11/08/2024

Entresto (a medication used to treat chronic heart failure): 09/06/2024, 09/07/2024, 09/09/2024, 09/22/2024

Furosemide (a medication used to help rid the body of extra water): 09/06/2024, 09/07/2024, 09/22/2024

Gabapentin (a medication used to prevent and control partial seizures and treat neuropathic pain): 09/01/2024 (1 of 3 doses), 09/06/2024 (2 of 3 doses), 09/07/2024 (1 of 3 doses), 09/09/2024 (1 of 3 doses), 09/22/2024 (2 of 3 doses)

Humalog/Lispro (fast-acting insulin): 09/01/2024 (2 of 4 doses), 09/06/2024 (2 of 4 doses), 09/07/2024 (1 of 4 doses), 09/09/2024 (2 of 4 doses), 09/22/2024 (2 of 4 doses), 10/13/2024 (1 of 4 doses), 11/08/2024 (1 of 4 doses), 11/09/2024 (1 of 4 doses), 11/10/2024 (1 of 4 doses), 11/11/2024 (2 of 4 doses)

Isosorb mono (a medication used to dilate blood vessels): 09/22/2024

Magnesium Oxide (a supplement): 09/06/2024, 09/07/2024, 09/22/2024

Potassium (a supplement): 09/06/2024, 09/07/2024, 09/22/2024

In an interview on 11/18/2024 at 10:01 AM, Staff A stated that they have not informed Resident 3's prescribing provider about the number and frequency of Resident 3's missed medications due to refusal.

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-2060 Preadmission assessment. The assisted living facility must conduct a preadmission assessment for each prospective resident that includes the following information, unless unavailable despite the best efforts of the assisted living facility:

(1) Medical history;

(2) Necessary and contraindicated medications;

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

(4) Significant known behaviors or symptoms that may cause concern or require special care;

(5) Mental illness diagnosis, except where protected by confidentiality laws;

(6) Level of personal care needs;

(7) Activities and service preferences; and

(8) Preferences regarding other issues important to the prospective resident, such as food and daily routine.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to complete preadmission assessments for 2 of 2 residents sampled for preadmission assessments (Resident 2 and 5). This failed practice placed the residents at risk of not receiving care they required on admission.

Findings included...

Review of Resident 2's undated medical file showed that they were admitted on [redacted]/2024. Further review showed that no preadmission assessment had been completed.

Review of Resident 5's undated medical file showed that Resident 5 was admitted on [redacted]/2024. Further review showed no preadmission assessment had been completed.

In an interview on 11/14/2024 at 10:30 AM, Staff A, Administrator, stated they could not provide any documentation that preadmission assessments had been completed for Residents 2 and 5, and was not aware of the requirement of the eight topics to be pre-assessed.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beyer — 12/20/2024

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 facility failed to ensure that negotiated service agreements were signed by residents, or the resident's representative, and facility representative for 6 of 7 residents (Resident's 1, 2, 3, 5, 6 and 7). This failure placed residents at risk of unmet care needs related to not signing and acknowledging their own plan of care.

Review of Resident 1's Negotiated Service Agreement (NSA) showed that it was not dated. Further review showed the resident was admitted on [redacted]2022, the agreement was signed by the resident but not the facility representative and there was no date indicating when the plan was updated.

Review of Resident 2's NSA dated 05/31/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

Review of Resident 3's NSA dated 10/27/2024 showed that the agreement was signed by the resident but not the facility representative.

Review of Resident 5's NSA dated 10/07/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

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, Magnolia Care 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 facility failed to ensure that negotiated service agreements were signed by residents, or the resident's representative, and facility representative for 6 of 7 residents (Resident's 1, 2, 3, 5, 6 and 7). This failure placed residents at risk of unmet care needs related to not signing and acknowledging their own plan of care.

Review of Resident 1's Negotiated Service Agreement (NSA) showed that it was not dated. Further review showed the resident was admitted on [redacted]/2022, the agreement was signed by the resident but not the facility representative and there was no date indicating when the plan was updated.

Review of Resident 2's NSA dated 05/31/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

Review of Resident 3's NSA dated 10/27/2024 showed that the agreement was signed by the resident but not the facility representative.

Review of Resident 5's NSA dated 10/07/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

Review of Resident 6's NSA dated 03/15/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

Review of Resident 7's NSA showed the resident was admitted on [redacted]2012 and was signed by the facility but was not dated or signed by the resident or the resident's representative.

In an interview on 11/14/2024 at 3:30 PM, Staff A, Administrator, acknowledged that the Resident's 1, 2, 3, 5, 6 and 7 NSA's were not all dated and signed by the resident, their representative or the facility and did not meet the regulation requirements.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025.

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

Britney Beg

Administrator (or Representative) — 12/20/2024 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to perform N95 fit testing for 4 of 5 staff (Staff B, C, D, and E) sampled for fit testing requirements. This failure placed residents at risk of contracting and spreading infections.

Review of Resident 6's NSA dated 03/15/2024 showed it was signed by the facility representative, but it was not signed by the resident or the resident's representative indicating agreement to the plan of care.

Review of Resident 7's NSA showed the resident was admitted on [redacted]/2012 and was signed by the facility but was not dated or signed by the resident or the resident's representative.

In an interview on 11/14/2024 at 3:30 PM, Staff A, Administrator, acknowledged that the Resident's 1, 2, 3, 5, 6 and 7 NSA's were not all dated and signed by the resident, their representative or the facility and did not meet the regulation requirements.

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, Magnolia Care 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-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to perform N95 fit testing for 4 of 5 staff (Staff B, C, D, and E) sampled for fit testing requirements. This failure placed residents at risk of contracting and spreading infections.

Findings included...

When implementing Transmission based precautions/Airborne Precautions required to reduce the spread of Covid 19 (a contagious respiratory virus), the CDC recommends healthcare personnel use a National Institute for Occupational Safety and Health (NIOSH) approved, fit-tested respirator for all encounters of suspected or confirmed airborne illnesses that can spread when an infected person coughs, sneezes, or talks. Fit testing is an activity where the seal of a respirator is tested to determine if it's adequate and is required to be completed annually to ensure continued effectiveness.

Review of Staff B's, Caregiver/Medication Technician (Med Tech), personnel record showed a hire date of 07/10/2024. Further review showed that no fit testing had been completed.

Review of the facility's staff schedule showed that Staff B provided resident care from 7:00 AM-9:00 PM on 11/03/2024, 3:00 PM-9:00 PM on 11/07/2024, and 3:00 PM-9:00 PM on 11/08/2024.

Review of Staff C's, Med Tech, personnel record showed a hire date of 04/13/2022. Further review showed that no fit testing had been completed.

Review of the facility's staff schedule showed that Staff C provided resident care from 7:00 AM – 5:30 PM on 10/22/2024, 10/23/2024, and 10/24/2024.

Review of Staff D's, Caregiver/Med Tech, personnel record showed a hire date of 05/02/2024. Further review showed that no fit testing had been completed.

Review of the facility's staff schedule showed that Staff D provided resident care from 8:00 PM - 8:00 AM on 10/20/2024, 10/21/2024, and 10/22/2024.

Review of Staff E's, Med Tech, personnel record showed a hire date of 09/13/2024. Further review showed that no fit testing had been completed.

Review of the facility's staff schedule showed that Staff E worked from 10:00 AM-6:30 PM on 10/20/2024, from 8:00 AM-6:00 PM on 10/21/2024, and 8:00 AM-6:00 PM on 10/23/2024.

In an interview on 11/19/2024 at 11:20 AM Staff A, Administrator, stated they did not have any fit testing records for Staff B, C, D, or E.

Plan/Attestation Statement

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Britney Begay — 12/20/2024

Administrator or Representative) — Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure specialty training for mental health, dementia and developmental disabilities was completed for 1 of 5 staff (Staff D). This failure placed residents at risk of improper care.

Findings included...

Review of the facility's undated characteristic roster, provided to the department on 11/13/2024, showed 34 residents listed with mental health and four residents listed with developmental disabilities. While there were no residents listed with dementia on this document, it was found that Resident 2 in the department's sample of 7 residents, had a diagnosis of [redacted].

Review of Staff D's, Caregiver/Medication Technician, personnel file showed they were hired on 05/02/2024. Further review showed no documentation for specialty training for mental health, dementia or developmental disabilities.

Review of the facility's staff schedule dated October 2024 and November 2024 showed that Staff D was assigned to care for residents from 6:00 PM-6:00 AM on the following

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure specialty training for mental health, dementia and developmental disabilities was completed for 1 of 5 staff (Staff D). This failure placed residents at risk of improper care.

Findings included…

Review of the facility's undated characteristic roster, provided to the department on 11/13/2024, showed 34 residents listed with mental health and four residents listed with developmental disabilities. While there were no residents listed with dementia on this document, it was found that Resident 2 in the department's sample of 7 residents, had a diagnosis of [redacted].

Review of Staff D's, Caregiver/Medication Technician, personnel file showed they were hired on 05/02/2024. Further review showed no documentation for specialty training for mental health, dementia or developmental disabilities.

Review of the facility's staff schedule dated October 2024 and November 2024 showed that Staff D was assigned to care for residents from 8:00 PM-8:00 AM on the following

days. 10/20/2024, 10/21/2024, 10/22/2024, 10/27/2024, 10/28/2024, and 10/29/2024.

In an interview on 11/19/2024 at 2:00 PM, Staff A, Administrator, stated that Staff D had not yet completed any specialty training for mental health, dementia and developmental disabilities.

Plan/Attestation Statement

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

Brittney Beg

Administrator (or Representative) — 12/20/2024 Date

WAC 388-78A-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a character, competence, and suitability review was completed for 1 of 5 staff (Staff E). This placed residents at risk of receiving services from staff members with non-disqualifying criminal convictions who were not evaluated for character, competence, and suitability to work with vulnerable adults.

Findings included...

Review of Staff E's, Medication Technician, personnel file showed a hire date of 09/13/2024 and an interim fingerprint background check dated 09/16/2024. Further review of the background check showed that Staff E had information from one or more background check sources that required a character, competence, and suitability (CC&S) review. No CC&S review was found in Staff E's file.

In an interview on 11/19/2024 at 02:50 PM, Staff A, Administrator, stated they had not completed a CC&S review for Staff E. By the conclusion of the departments survey, Staff

days: 10/20/2024, 10/21/2024, 10/22/2024, 10/27/2024, 10/28/2024, and 10/29/2024.

In an interview on 11/19/2024 at 2:00 PM, Staff A, Administrator, stated that Staff D had not yet completed any specialty training for mental health, dementia and developmental disabilities.

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-24701 Background checks Employment Nondisqualifying information.

(1) If the background check results show that an employee or prospective employee has a criminal conviction or pending charge for a crime that is not a disqualifying crime under chapter 388-113 WAC, then the assisted living facility must determine whether the person has the character, competence and suitability to work with vulnerable adults in long-term care.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a character, competence, and suitability review was completed for 1 of 5 staff (Staff E). This placed residents at risk of receiving services from staff members with non-disqualifying criminal convictions who were not evaluated for character, competence, and suitability to work with vulnerable adults.

Findings included…

Review of Staff E's, Medication Technician, personnel file showed a hire date of 09/13/2024 and an interim fingerprint background check dated 09/16/2024. Further review of the background check showed that Staff E had information from one or more background check sources that required a character, competence, and suitability (CC&S) review. No CC&S review was found in Staff E's file.

In an interview on 11/19/2024 at 02:50 PM, Staff A, Administrator, stated they had not completed a CC&S review for Staff E. By the conclusion of the departments survey, Staff

A had provided a final fingerprint, and a CC&S review dated 11/20/2024.

Plan/Attestation Statement

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Britney Beg

Administrator (or Representative) — 12/20/2024 Date

WAC 388-78A-2850 Required reviews of building plans.

(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as an assisted living facility;

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to notify construction review services before constructing two supportive structures in 1 of 2 medication stations (Medication Station 1). This failure placed residents at risk of hazards related to walking and sitting under structural supports constructed without department oversight.

Findings included...

An observation on 11/19/2024 at 10:40 AM showed two supportive structures in the nursing station on the enhanced adult residential care side of the building, with beams approximately 12 inches high that span approximately 12 feet wide and were attached horizontally to the ceiling. These beams were supported by two wooden posts approximately 4 inches by 4 inches running vertical approximately seven feet tall. Each vertical post was standing on a base of wood approximately 4 inches high and approximately 12 inches by 12 inches wide and long. The posts supporting the beams were approximately 10 feet apart.

A had provided a final fingerprint, and a CC&S review dated 11/20/2024.

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

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(1) A person or assisted living facility must notify construction review services of all planned construction regarding an assisted living facility prior to beginning work on any of the following:

(a) A new building or portion thereof to be used as an assisted living facility;

(b) An addition of, or modification or alteration to an existing assisted living facility, including, but not limited to, the assisted living facility's:

(i) Physical structure;

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to notify construction review services before constructing two supportive structures in 1 of 2 medication stations (Medication Station 1). This failure placed residents at risk of hazards related to walking and sitting under structural supports constructed without department oversight.

Findings included...

An observation on 11/19/2024 at 10:40 AM showed two supportive structures in the nursing station on the enhanced adult residential care side of the building, with beams approximately 12 inches high that span approximately 12 feet wide and were attached horizontally to the ceiling. These beams were supported by two wooden posts approximately 4 inches by 4 inches running vertical approximately seven feet tall. Each vertical post was standing on a base of wood approximately 4 inches high and approximately 12 inches by 12 inches wide and long. The posts supporting the beams were approximately 10 feet apart.

In an interview on 11/13/2024 at 12:17 PM, Staff F, Owner, stated that they did not contact construction review services before completing the support beam structures and were not aware that they needed to since they just adding support and were not changing the building in any way.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beg

Administrator / Representative) 12/20/2024 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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff had a Washington state name and date of birth background check submitted to the department's background check central unit every two years for 2 of 5 staff (Staff A and C). This failure placed residents at risk of receiving care and services by potentially disqualified staff.

Findings included...

Review of Staff A's, Administrator, personnel file showed Staff A was hired on 09/12/2010. Further review showed a final fingerprint dated 11/18/2020 and no Washington state name and date of birth background check was completed within the

In an interview on 11/13/2024 at 12:17 PM, Staff F, Owner, stated that they did not contact construction review services before completing the support beam structures and were not aware that they needed to since they just adding support and were not changing the building in any way.

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, Magnolia Care 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

(b) There is a valid Washington state name and date of birth background check for all administrators, caregivers, staff persons, volunteers and students.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff had a Washington state name and date of birth background check submitted to the department’s background check central unit every two years for 2 of 5 staff (Staff A and C). This failure placed residents at risk of receiving care and services by potentially disqualified staff.

Findings included…

Review of Staff A’s, Administrator, personnel file showed Staff A was hired on 09/12/2010. Further review showed a final fingerprint dated 11/18/2020 and no Washington state name and date of birth background check was completed within the

last two years.

In an interview on 11/19/2024 at 2:30 PM, Staff F, Owner, stated they were having difficulties retrieving Staff A's background check from the state computer system and would continue to attempt to retrieve it. At the conclusion of the extension provided by the department to provide documentation by 11/22/2024 at 5:00 PM, no background check information was received from the facility.

Review of Staff C's, Med Tech, personnel file showed Staff C was hired on 04/13/2022. Further review showed a final fingerprint dated 09/06/2022 and no Washington state name and date of birth background check was completed within the last two years.

In an interview on 11/19/2024 at 3:05 PM, Staff A, stated no Washington state background check had been completed for Staff C within the last 2 years.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beggs — 12/20/2024

Administrator (or Representative) — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure new employees were screened for tuberculosis within three days of hire for 2 of 7 sampled staff (Staff D and E). This failure placed residents at risk for exposure to tuberculosis.

Findings included...

Review of Staff D's, Caregiver/Medication Technician (Med Tech) personnel file showed they were hired on 05/02/2024. Further review showed that Staff D did not have a tuberculosis (TB, a communicable respiratory disease) screening completed.

last two years.

In an interview on 11/19/2024 at 2:30 PM, Staff F, Owner, stated they were having difficulties retrieving Staff A's background check from the state computer system and would continue to attempt to retrieve it. At the conclusion of the extension provided by the department to provide documentation by 11/22/2024 at 5:00 PM, no background check information was received from the facility.

Review of Staff C's, Med Tech, personnel file showed Staff C was hired on 04/13/2022. Further review showed a final fingerprint dated 09/06/2022 and no Washington state name and date of birth background check was completed within the last two years.

In an interview on 11/19/2024 at 3:05 PM, Staff A, stated no Washington state background check had been completed for Staff C within the last 2 years.

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, Magnolia Care 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-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure new employees were screened for tuberculosis within three days of hire for 2 of 7 sampled staff (Staff D and E). This failure placed residents at risk for exposure to tuberculosis.

Findings included...

Review of Staff D's, Caregiver/Medication Technician (Med Tech) personnel file showed they were hired on 05/02/2024. Further review showed that Staff D did not have a tuberculosis (TB, a communicable respiratory disease) screening completed.

Review of the facility's staff schedule showed that Staff D provided resident care from 8:00 PM-8:00 AM on 10/20/2024, 10/21/2024, and 10/22/2024.

Review of Staff E's, MedTech, personnel file showed they were hired on 09/13/2024. Further review showed that Staff E did have an unread tuberculosis test on 11/05/2024 that did not meet the requirement of getting screened within three days of hire.

Review of the facility's staff schedule showed that Staff E worked from 10:00 AM-6:30 PM on 10/20/2024, from 8:00 AM-6:00 PM on 10/21/2024, and 8:00 AM-6:00 PM on 10/23/2024.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Britney Beg

Administrator (Or Representative) — 12/20/2024 Date

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Review of the facility's staff schedule showed that Staff D provided resident care from 8:00 PM-8:00 AM on 10/20/2024, 10/21/2024, and 10/22/2024.

Review of Staff E's, MedTech, personnel file showed they were hired on 09/13/2024. Further review showed that Staff E did have an unread tuberculosis test on 11/05/2024 that did not meet the requirement of getting screened within three days of hire.

Review of the facility's staff schedule showed that Staff E worked from 10:00 AM-6:30 PM on 10/20/2024, from 8:00 AM-6:00 PM on 10/21/2024, and 8:00 AM-6:00 PM on 10/23/2024.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

In an interview on 11/19/2024 at 12:25 PM, Staff A, Administrator, stated that they did not have any documentation of Staff D's TB testing and confirmed that Staff E was not tested within three days of hire.

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, Magnolia Care 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-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to obtain a medical testing site waiver license to perform on-site blood sugar testing for 2 of 7 sampled residents (Resident 2 and 3). This failure resulted in the facility performed glucose testing for two residents without oversite which placed residents at risk of receiving inaccurate test results.

Findings included…

Review of a Department of Social and Health Services provider letter dated 08/03/2022, showed that certain types of medical testing require a state Medical Test Site Waiver (MTSW) license. One type of activity requiring a MTSW license is for testing blood glucose for a resident.

Per Department of Health WAC 246-338 Medical Test Site Rules, under sections 246-338-001 through 246-338-020, facilities that performed on-site medical tests were required to obtain a test waiver for tests that may indicate medical treatment and were required to follow chapter 70.42 RCW Medical Test Sites.

Review of RCW 70.42 Medical Test Sites, showed it was established to regulate licensing standards for medical test sites, consistent with federal law and regulation, related to quality control, quality assurance, records, personnel requirements, proficiency testing, and licensure waivers.

Review of the CLIA (Clinical Laboratory Improvement Amendments) database showed the facility did not have a MTSW license.

Review of Resident 2's Negotiated Service Agreement (NSA) dated 05/31/2024 showed that staff were to oversee medication administration, and that Resident 2 required blood sugar checks daily.

Review of Resident 3's undated NSA showed that Resident 3 required medication assistance from the facility including blood glucose monitoring.

In an interview on 11/15/2024 at 3:15 PM Staff A, Administrator, confirmed the facility completes blood sugar testing for residents and that their MTSW license had expired.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025

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

Brittney Beg

Administrator (or Representative) — Date: 12/20/2024

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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 facility failed to monitor, identify changes, evaluate and take appropriate action for 4 of 7 sampled residents (Resident 1, 2, 3 and 6). This failure placed the residents at risk of worsening and serious health complications and risk of injury due to falls.

Findings included...

<Resident 3>

Review of Resident 3's face sheet showed diagnoses of [redacted]

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, Magnolia Care 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:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(b) Recurring condition in a resident's physical, emotional, or mental functioning that has previously required intervention by others.

(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 facility failed to monitor, identify changes, evaluate and take appropriate action for 4 of 7 sampled residents (Resident 1, 2, 3 and 6). This failure placed the residents at risk of worsening and serious health complications and risk of injury due to falls.

Findings included…

<Resident 3>

Review of Resident 3’s face sheet showed diagnoses of [redacted]

[redacted] and [redacted].

Review of Resident 3's Negotiated Service Agreement (NSA) dated 10/27/2024 showed that Resident 3 required medication assistance from the facility.

Resident 3 Blood pressures

Review of Resident 3's Comprehensive Assessment Reporting Evaluation (CARE's) assessment dated 11/01/2024 showed that facility staff are to take blood pressures twice daily.

Review of an After Visit Summary dated [redacted]/2024 showed that Resident 3 was hospitalized at Holy Family Hospital from [redacted]/2024 – [redacted]/2024 due to a hypertensive (high blood pressure) emergency.

Review of Resident 3's September 2024 and October 2024 Medication Administration Record (MAR) showed that the facility used Quick MAR (an electronic medical management system) to document medication administration. Further review showed pulse and blood pressure readings taken twice daily through 10/14/2024.

Review of Resident 3's October 2024 and November 2024 MAR showed that the facility switched to Bluestep (an electronic medical management system) to document medication administration beginning 10/15/2024. Further review showed no documentation of blood pressure readings beginning 10/15/2024 and no place for staff to record it.

In an interview on 11/19/2024 at 2:43 PM, Staff A, Administrator, stated that they do not have documentation of blood pressures taken after 10/14/2024.

Resident 3 Out of facility

Review of the undated facility policy "Medication Documentation Policy for Assisted Living Facilities in Washington State" showed that the prescribing provider should be notified if the missed or refused dose poses a risk to the resident's health.

Review of the "Medication Service: Administration of Prescribed Medications/Treatments" from the Magnolia Care Policy Manual showed that when the resident is on leave from the facility, the time left and time returned should be documented in the nursing notes.

Review of Resident 3's NSA dated 10/27/2024 showed that Resident 3 "will sometimes be resistive to medications. [They] will also leave the facility, not taking [their] medications with them."

Review of Resident 3's September 2024, October 2024, and November 2024 MAR showed that 75 doses of the resident's following medications were not administered due to Resident 3 being "out of the facility":

Amlopidine (a medication used to lower blood pressure): 11/06/2024

Aspirin (a medication used to lower the risk of heart attack and stroke): 09/04/2024, 09/20/2024, 10/23/2024, 11/06/2024

Atorvastatin (a medication used to lower cholesterol and triglycerides (fats) levels to help prevent heart disease, strokes, and heart attacks): 09/03/2024, 09/19/2024,10/23/2024,11/04/2024

Basaglar Kwikpen (a long-acting insulin used to treat diabetes): 09/04/2024, 09/20/2024

Carvedilol (a medication used to treat heart failure and high blood pressure): 09/03/2024, 09/04/2024, 09/19/2024, 09/20/2024, 10/23/2024, 10/25/2024, 11/04/2024, 11/06/2024

Entresto (a medication used to treat chronic heart failure): 09/03/2024, 09/04/2024, 09/19/2024, 09/20/2024

Ferrous Sulfate (iron supplement): 10/23/2024, 10/25/2024, 11/06/2024

Furosemide (a medication used to help rid the body of extra water): 09/04/2024, 09/20/2024, 10/23/2024, 10/25/2024

Gabapentin (a medication used to prevent and control partial seizures and treat neuropathic pain): 09/03/2024 (1 of 3 doses), 09/04/2024 (2 of 3 doses), 09/05/2024 (1 of 3 doses), 09/07/2024 (1 of 3 doses), 09/13/2024 (1 of 3 doses), 09/19/2024 (2 of 3 doses), 09/20/2024 (2 of 3 doses), 10/23/2024 (2 of 2 doses), 10/25/2024 (1 of 2 doses), 11/04/2024 (1 of 2 doses), 11/06/2024 (1 of 2 doses)

Humalog/Lispro (fast-acting insulin): 09/02/2024 (1 of 4 doses), 09/03/2024 (1 of 4 doses), 09/04/2024 (2 of 4 doses), 09/05/2024 (1 of 4 doses), 09/07/2024 (1 of 4 doses), 09/13/2024 (2 of 4 doses), 09/17/2024 (3 of 4 doses), 09/19/2024 (2 of 4 doses),

09/20/2024 (2 of 4 doses), 10/23/2024 (4 of 4 doses), 10/25/2024 (1 of 4 doses), 11/04/2024 (2 of 4 doses), 11/06/2024 (1 of 4 doses)

Magnesium Oxide (a supplement): 09/04/2024, 09/20/2024

Potassium (a supplement): 09/04/2024, 09/20/2024, 10/23/2024

Senna-Time (used to treat constipation): 10/23/2024, 11/04/2024

Review of the September 2024, October 2024, and November 2024 nursing notes showed no entries documenting the time Resident 3 left and time Resident 3 returned in the nursing notes.

In an interview on 11/15/2024 at 2:10 PM, Staff C, Medication Technician (Med Tech), stated that they have packed Resident 3's medications when the resident let staff know they would be going out and asked for their medications. Staff C further stated that if the MAR read "out of facility" it is because Resident 3 did not ask for their medications before leaving the facility.

In an interview on 11/18/24 at 10:01 AM, Staff A stated that they have not informed Resident 3's provider about the number and frequency of Resident 3's missed medications due to being out of the facility. Staff A further stated that if the times that Resident 3 left the facility and returned are not recorded in the nurse's notes, they were not documented.

Resident 3 No documentation with provider when Blood Sugar > 400

Review of Resident 3's prescription for lispro insulin injections (fast acting insulin) showed a sliding scale. Further review showed that when the resident's blood sugar (BS) read 400 and greater, staff are to give 6 units and notify the primary care provider (PCP).

Review of Resident 3's September 2024, October 2024, and November 2024 MAR showed four blood sugar readings of 400 and greater:

09/02/2024 8:00 AM BS 483
09/02/2024 8:00 PM BS 417
09/22/2024 8:00 PM BS 470
11/02/2024 12:00 PM BS 419

Review of Resident 3's September 2024, October 2024, and November 2024 nursing

notes showed no documentation related to the blood sugars readings of 400+ and no documentation of contact with their PCP.

In an interview on 11/15/2024 at 10:32 AM, Staff C, stated that when Resident 3's blood sugar is over 400 they are required to call the provider and document the call in the nurse's notes. When presented with the nurse's notes provided to the department, Staff C confirmed the notes were complete. Staff C checked the electronic system and stated that there were no additional notes documented in the electronic system. Staff C further stated that if there are no calls to the provider regarding Resident 3's blood sugar in the nurse's notes, the calls were not documented.

In an interview on 11/19/2024 at 2:43 PM, Staff A stated that the care staff should have documented calls to the provider for Resident 3's blood sugars over 400 in the nurse's notes. Staff A further stated that if the calls are not documented in the nurse's notes, they do not have record of the calls.

<Resident 1>

Review of Resident 1's Comprehensive Assessment Reporting Evaluation (CARE) dated 01/18/2024 showed a diagnosis of [redacted] and [redacted].
Further review showed that the resident had developed cellulitis (skin infection) due to edema if legs were not elevated.

Review of Resident 1's undated Negotiated Service Agreement (NSA) showed that the resident required medication assistance from the facility, assistance with bathing, and placing their compression socks on, and that they have a history of multiple skin infections in their legs due to edema.

Review of Resident 1's facility's nursing notes for September, October and November 2024 showed that in its entirety it included:
09/08/2024: The resident had a food related incident not related to health conditions.
[redacted]/2024: The resident experienced low blood oxygen level of 74 and was having trouble breathing, they were sent to the hospital by ambulance.
[redacted]/2024: The resident came home from the hospital with oxygen and a couple of new medications.
11/11/2024: The resident had gone out again to the hospital, same as last month and has an appointment to see cardiology department in December.

Review of Resident 1's hospital records showed that Resident 1 was hospitalized on [redacted]/2024-[redacted]/2024 and again on [redacted]/2024-[redacted]/2024, that both times were for acute hypoxic (lack of oxygen) respiratory failure, and that the resident was treated in the hospital with increased liters of oxygen, breathing treatments to reduce difficulty breathing, diuretics to decrease fluid overload, steroids to decrease inflammation in the lungs, and other medical tests and medication treatment.
Further review showed that

when Resident 1 returned from the hospital on [redacted]/2024 they required continuous oxygen at 2 liters per minute via mask (administered to nose and mouth) or nasal cannula (tubing to receive oxygen through the nose).

Review of Resident 1's hospital records physician progress notes dated 11/07/2024 showed the resident's admission was preceded by reported issues with the valve on their transportable oxygen and the resident had been off of their normal oxygen supplementation the week prior. Further review showed that the resident also developed worsening edema in both of their legs during this hospitalization.

An observation on 11/14/2024 at 1:15 PM, during Resident 1's interview showed that they were wearing an open oxygen face mask and were receiving oxygen from an oxygen concentrator at 2 liters per minute continuously.

In an interview on 11/14/2024 at 2:00 PM, Staff C, stated they did not check Resident 1's oxygen level because there were no instructions to do that.

In an interview on 11/14/2024 at 2:20 PM, Staff G, Med Tech Supervisor, stated that Resident 1 had not been on any alert charting for respiratory distress or leg edema after each hospital stay and that any documentation related to Resident 1 is contained in the nursing notes. Staff G further stated that Resident 1's vital signs were only taken monthly.

Review of Resident 1's recorded vital signs on a 'Monthly Vital Signs' sheet with all of the resident's vital sign recordings showed that Resident 1's were taken once a month in September 2024, October 2024, and November 2024 and none of Resident 1's records contained a pulse oximeter (screening for oxygen level with a finger monitor) oxygen level for Resident 1.

Review of Resident 1's Medication Administration Records (MAR) for October 2024, September 2024, and November 2024 showed no indications for monitoring the resident's pulse oxygenation level, their oxygen use or how many liters of oxygen they should be continuously receiving, or to monitor the swelling in Resident 1's lower legs.

Review of Resident 1's facility medical file up to 11/15/2024 showed that there was no documentation of any facility monitoring of the resident's health condition before or after their hospitalization dates or if anyone had been notified of the residents change of condition, leaving to go to the hospital, or their return from both hospitalizations, including the resident's primary physician, case manager, or family of the resident.

In an interview on 11/15/2024 at 11:45 AM, Staff I, Registered Nurse, stated they did not assess Resident 1 when they came back from the hospital and had not reviewed their hospital records or any discharge orders from the hospital. Staff I further stated that they did not know if the doctor was notified on their return from recent hospital stays,

or if that was required.

In an interview on 11/15/2024 at 2:00 PM, Staff A, stated that they did not see any discharge orders for Resident 1 when they returned from the hospital and could not provide documentation that they notified the primary care physician when Resident 1 left to go to the hospital or when they returned from the hospital either time.

<Resident 6>

Review of the facility's undated "Fall Assessment and Prevention" policy showed that all residents who have fallen shall be given a fall assessment by a licensed nurse, and that this information shall be used to formulate an individualized fall prevention plan within the NSA. Further review showed that after a fall staff are required to take vital signs and inquire as to areas of pain/discomfort, notify administration by phone or pager and resident's guardian or next of kin, and complete an incident report, including vital signs, and results of investigation. Review of Resident 6's undated face sheet showed diagnoses of [redacted] and [redacted]

Review of Resident 6's NSA dated 03/15/2024 showed that Resident 6 walks independently without any assistive devices in their room and immediate living environment, and only requires assistance outside of the immediate living environment. Further review showed no reference to falls or fall risk. Further review showed that staff are to "report any concerns regarding mobility to administration."

Review of Resident 6's Nurse's Notes showed notes on 07/15/2024, 10/28/2024, and 11/07/2024 that indicated that Resident 6 had fallen. Further review showed that the note on 07/15/2024 read that Resident 6 "had once again fallen in [their] room."

In an interview on 11/19/2024 at 10:43 AM, Resident 6 stated that they have fallen in their apartment several times and that they do not know why. Resident 6 stated that they remember walking and then being on the floor. They stated that they land on their knees. Resident 6 further stated that they do not tell staff every time they fall.

They stated that the last time they fell down they were unable to stand up and that the only way they could see to get out of the door was to go out into the hallway on their bottom. Resident 6 stated that they do not like falling and that "it is scary."

In an interview on 11/19/2024 at 10:02 AM, Staff A stated that they were unaware that Resident 6 had fallen on multiple occasions. Staff A confirmed that they have not received any incident reports for unwitnessed falls for Resident 6.

In an interview on 11/19/2024 at 10:07 AM, Staff H, Caregiver, stated that Resident 6 had fallen in their room on several occasions. They stated that Resident 6 had a history of falling prior to their note on 07/15/2024 and that they documented the falls in the nurse's notes. They stated that they are often only aware of the falls when they observe abrasions on Resident 6's knees when they provide shower assistance. Staff H stated they did not request evaluation of Resident 6 following the incident on 11/07/2024 when Resident 6 scooted into the hallway on their bottom. When asked what they meant when they noted 'will monitor' in each of the nurse's notes, Staff H stated they perform visual checks but do not document anything further. When asked if they completed an incident report following any of the falls, Staff H stated they do not believe so but may have for the fall on 11/07/2024. Staff H further stated they do not know why Resident 6 has fallen but that they may have tripped over items on their floor.

<Resident 2>

Review of Resident 2's face sheet showed a diagnosis of [redacted].

Review of Resident 2's CARE's assessment dated 03/12/2024 stated that Resident 2 requires assistance with blood sugar monitoring daily.

Review of Resident 2's NSA dated 05/31/2024 stated that staff were to oversee medication administration, to document administration and monitor and report any concerns regarding medication management to administration.

Review of Resident 2's MAR's dated September 2024, October 2024 and November 2024 showed an order to give Lantus daily in the morning (long-acting insulin used to lower blood sugar), and to raise the dose by 2 units if the resident's blood sugar was over 200. Further review showed that when the previous medication documentation program stopped being in use at the end of September, there was no longer an area to document blood sugars from October 15, 2024 through November 13, 2024. This resulted in not being able to monitor the resident's blood sugar which would have indicated if the medication needed to be adjusted.

In an interview on 11/18/2024 at 3:05 PM, Staff I, stated there had been no blood sugars documented for Resident 2 since their new medication administration system had been implemented in October and confirmed this was an error.

In an interview on 11/18/2024 at 3:30 PM Staff L, Med Tech, stated there had been

nowhere to document Resident 2's blood sugar results so they were not documenting them.

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, Magnolia Care is or will be in compliance with this law and / or regulation on (Date) January 17, 2025 .

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

Britney Beg

Administrator (Or Representative)

12/20/2024

Date

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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, Magnolia Care 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