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

03/07/2025

Summer Hill Operations, LLC
Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

RE: Summer Hill Assisted Living # 2676

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 56004 (Completion Date 03/07/2025) and 50396 (Completion Date 01/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/07/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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.

The Department staff who did the On Site verification:
Melissa Phillips, Long Term Care Surveyor

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Summer Hill Assisted Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2676
Intake ID: 152225
Compliance Determination #: 50396
Region/Unit #: RCS Region 2 / Unit A
Investigator: Teresa Pederson-Tuley
Investigation Date(s): 11/18/2024 through 01/13/2025
Complainant Contact Date(s):

Allegation(s):
The Identified Staff was verbally abusive toward the Named Resident (NR) and did not serve them meals in a timely manner.

Investigation Methods:

Sample:	Total residents: 53 Resident sample size: 3 Closed records sample size: 0
Observations:	Kitchen Staff to resident interactions
Interviews:	Nursing staff Kitchen staff Identified resident
Record Reviews:	Medical records Facility policies Staff training records Meal service policies

Investigation Summary:
Interview with the NR stated that they had anxiety, depression and thought the IS staff were ignoring and verbally abusing them by not serving a meal to them when they arrived in the dining room. The NR stated they expected to be served right away, communicated this by yelling at the kitchen staff and stated they were being verbally abused when the kitchen staff talked back to them. Interview with the Dietary Manager stated they had attempted to serve the NR quicker, had made several attempts to work with the NR, rotated kitchen staff to serve the NR, they had not been satisfied with any plan and continued to yell threats at staff. Interview with the Director of Nursing (DON) and Executive Director (ED) stated that they were aware of this allegation, they had met with the NR to make a plan, but the NR continued to be verbally aggressive toward staff. Record review of the Progress Notes showed the NR had been placed on alert charting for yelling at kitchen staff stating they had ignored them, and the care plan had been updated with new behavior interventions. The ALF had notified the physician, nursing staff and

Executive Director (ED). There have been no further incidents. The ALF investigated and ruled out abuse and neglect.

Record review showed missed medications. Failed practice found and a citation for Washington Administrative Code (WAC) 388-78A-2240 Nonavailability of Medications, was written.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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

The department completed data collection for an unannounced on-site complaint investigation on 11/18/2024 and 11/18/2024 of:

Summer Hill Assisted Living
165 SW 6th Ave
Oak Harbor, WA 98277

This document references the following complaint number(s): 152225

The following sample was selected for review during the unannounced on-site visit: 3 of 53 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

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

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

Residential Care Services

Date

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

Administrator (or Representative) Date

WAC 388-78A-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 interviews and record reviews the Assisted Living Facility (ALF) failed to obtain medications in a correct and timely manner for 1 of 3 residents (Resident 1). This failure resulted in Resident 1 missing 222 doses of antidepressant medication, 35 doses of anticonvulsant medication and placed all residents who received medication assistance at risk for unmet needs.

Findings included…

Review of the ALF's undated policy "Medication Ordering and Delivery" showed that the ALF is to have medications ordered and delivered in a timely and efficient manner to promote an excellent medication system.

Review of the ALF's undated policy "Unavailable Medications" showed that it is the policy of the ALF to provide medication to residents in a timeframe and in a manner that promotes health and welfare; (2) If, despite negotiations and plans set between the ALF and the pharmacy, a medication is not available to a resident at a designated timeframe, the designated staff person will contact the pharmacy to determine when the medication will be delivered. Additionally, staff shall submit the information to the prescribing health care professional to attempt to expedite the refill process. (3) If the ALF employs a licensed nurse, the designated staff person will contact the licensed nurse, who will evaluate the significance of the medication not being delivered to the resident on time and take the appropriate actions to ensure resident safety and welfare.

Review of the undated Face Sheet showed Resident 1 was admitted on [redacted]/2023 with multiple medical diagnoses including [redacted] and [redacted].

A Negotiated Service Agreement (NSA) dated 10/08/2024 showed Resident 1 had requested that staff were to provide medication assistance and reorder medications.

A Medication Administration Record (MAR) dated July 2024 showed Resident 1 was

prescribed Escitalopram (treatment for depression) 10mg tablet daily, Mirtazapine (treatment for depression) 15 mg daily, and Gabapentin (treatment for numbness) 300mg 3 times daily.

A MAR dated July 2024 showed Resident 1 did not receive 25 doses of Escitalopram on the following dates: July 7-31; and 24 doses of Mirtazapine July 8-31. The medications were noted to be unavailable.

Progress Notes dated 07/16/2024, showed that Resident 1 physician had been faxed for new medication prescriptions and that medications had run out.

A MAR dated August 2024 showed Resident 1 did not receive 31 doses of Escitalopram on the following dates: August 1-31; and 31 doses of Mirtazapine August 1-31. The medications were noted to be unavailable.

Progress Note dated 08/12/2024, showed that Resident 1 had been out of 2 medications, and that the medications were ordered.

A MAR dated September 2024 showed Resident 1 did not receive 30 doses of Escitalopram on the following dates: September 1-30; and 30 doses of Mirtazapine September 1-30. The medications were noted to be unavailable.

Progress Note dated 09/16/2024 showed the physician had been faxed because the ALF had been unable to obtain the medication Mirtazapine.

A MAR dated October 2024 showed Resident 1 did not receive 31 doses of Escitalopram on the following dates: October 1-31; and 30 doses of Mirtazapine October 1-25, 27-31. The medications were noted to be unavailable.

Progress Note dated 10/15/2024 showed that Resident 1 reported to a caregiver that they were feeling depressed.

Progress Note dated 10/15/2024 showed that Resident 1 reported they were having a panic attack/anxiety attack.

A MAR dated November 2024 showed Resident 1 did not receive 35 doses of Gabapentin on the following dates: November 5-16.

Review of fax dated 09/16/2024 showed that the physician notified the ALF that Resident 1 needed an appointment before writing the prescription.

Review of an email sent to facility staff 09/18/2024 showed that the resident needed a physician appointment set up about medications.

On 11/18/2024 at 11:13 AM, Staff B, Medication Technician (MT), stated the pharmacy sent the medications monthly for each resident and that if a medication was running low before the monthly fill arrived, the policy was to notify the nurse and fax the pharmacy. Staff B stated that they were aware that the NR had not received medications for several months and that they had notified Staff A, Director of Nursing.

On 11/18/2024 at 12:50 PM, Staff A stated the ALF was responsible for Resident 1's medication management including ordering medications. They been made aware of the missed medications by staff, and were aware Resident 1 had stated they were depressed and had anxiety when the medication doses were missed. Staff A thought that Resident 1 had scheduled and cancelled physician appointments but did not follow up to obtain that information.

On 11/18/2024 at 1:34 PM, Collateral Contact, primary care physician, stated there had been no phone calls to refill medications and there had not been appointments made or cancelled by Resident 1 from 07/2024-09/2024.

On 11/18/2024 at 2:30 PM, Resident 1 stated that they were aware that the medications were not being given, felt emotionally different when they had not received the medications and had reported feeling depressed and anxious while off the medication. Resident 1 stated that they thought the nurse was working with the physician to get the medications.

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, Summer Hill Assisted Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date