STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Wellspring Centralia LLC

Wellspring Centralia LLC
1215 S Tower Ave
Centralia, WA 98531

RE: Wellspring Centralia LLC License # 2685

Dear Administrator:

This letter addresses Compliance Determination(s) 69139 (Completion Date 11/21/2025) and 65812 (Completion Date 10/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2025 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-2160, WAC 388-78A-2665, WAC 388-78A-2665-1, WAC 388-78A-2665-2, WAC 388-78A-2665-3, WAC 388-78A-2665-4, WAC 388-78A-2665-5, WAC 388-78A-2665-6, WAC 388-78A-2100-2-b-i, WAC 388-78A-2040-1, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-b

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 09/18/2025 of:
Wellspring Centralia LLC
1215 S Tower Ave
Centralia, WA 98531

This document references the following SOD dated: 10/01/2025

The following sample was selected for review during the unannounced on-site visit: 3 of 12 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Clinton Fridley
Residential Care Services

10/10/2025
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.

Kari Sethofer
Administrator (or Representative)

10/19/25
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the resident's Service Agreement (facility's version of the negotiated service plan) was followed and implemented for 1 of 3 sampled memory care residents (Resident 3 [R3]). This failure placed R3 at risk for medical complications, decreased quality of life, and possible hospitalization.

Findings included...

Record review of the facility's policy titled, "Change of Service for Resident", undated, showed the policy applied to all staff involved in assessment, planning, and delivery of services to the residents at the facility. The section "procedure implementation" showed the interdisciplinary team shall implement the changes in services according to the resident's care plan and individualized needs.

Record review of R3's Admission Record, dated 09/18/2025, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included vascular [redacted] and [redacted].

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

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the resident's Service Agreement (facility's version of the negotiated service plan) was followed and implemented for 1 of 3 sampled memory care residents (Resident 3 [R3]). This failure placed R3 at risk for medical complications, decreased quality of life, and possible hospitalization.

Findings included…

Record review of the facility's policy titled, "Change of Service for Resident", undated, showed the policy applied to all staff involved in assessment, planning, and delivery of services to the residents at the facility. The section "procedure implementation" showed the interdisciplinary team shall implement the changes in services according to the resident's care plan and individualized needs.

Record review of R3's Admission Record, dated 09/18/2025, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

In an interview on 09/18/2025 at 12:26 PM, Staff C, Nursing Caregiver, stated the caregivers get paper copies of the resident's service plans when they were updated and once the caregivers review the updated service plan, the caregivers sign and date them to show they were reviewed. Staff C stated that R3's service plan just recently changed yesterday and provided R3's updated service plan that was at the nurses station. The service plan showed caregiver's signatures and dated 09/17/2025 on the front of the service plan.

Record review of R3's Resident Service Plan, undated, that was recently updated that caregivers signed off on 09/17/2025 and 09/18/2025, showed R3 demonstrated inappropriate judgement, behavior, and ability to function in social settings. On 05/07/2025 it was initiated that R3 requires a controlled carbohydrate diet with a pureed (food that is blended smooth) texture, and nectar (liquids that are thicker than honey) thick liquids. R3 had swallowing difficulties that required them to have a mechanically altered diet. Care staff were to report any changes in R3's ability to eat or drink.

Record review of R3's visual bedside individual service plan report, dated 09/18/2025, documented staff would report any changes in R3's ability to eat or drink and was on a pureed diet with nectar thick liquids related to swallowing difficulties.

In an interview and observation on 09/18/2025 at 12:36 PM, Staff C stated R3 could feed themselves and ate normal consistency of food that the caregivers had to chop up and regular thin liquids. At 12:47 PM in the dining room, R3 was sitting at a table with another female with two clear cups and one had regular consistency water with ice inside. At 1:08 PM, R3 was eating lunch that consisted of whole breaded chicken breast with white gravy on top, whole baked beans, and whole kernels of corn. None of the food R3 was observed eating was pureed consistency as the service plan directed. R3 was observed to pick up the cup of thin water and drink it. Staff E, Nursing Medication Technician, stood near R3 while they ate their lunch.

In an interview on 09/18/2025 at 1:18 PM, in the kitchen, Staff F, Dietary, stated R3 was on a general regular diet with thin liquids. Staff F was unsure if R3 was to have mechanical soft food.

In an interview and observation on 09/18/2025 at 2:57 PM, Staff B, Director of Nursing, reviewed R3's service plan that was at the nurses station dated 09/17/2025 and stated that was R3 most updated service plan they had just completed yesterday. Staff B stated R3's diet per the service plan was pureed with nectar thick liquids. Staff B stated the caregivers and the dietary staff were to serve the diet that was on the residents service plan.

This is an uncorrected deficiency previously cited on 07/23/2025.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) 11/15/25

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

Kari Scotterbeck — Administrator (or Representative)

10/19/25 — Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point, and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 2 of 4 sampled Residents (Resident 3 [R3], and Resident 4 [R4]). This failure placed both residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included...

Record review of R3's Admission Record, dated 09/18/2025, showed R3 moved into the facility on [redacted]/2025.

Record review of R4's Admission Record, dated 09/28/2025, showed R4 moved into the facility on [redacted]/2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

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Administrator (or Representative) Date

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(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 2 of 4 sampled Residents (Resident 3 [R3], and Resident 4 [R4]). This failure placed both residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included…

Record review of R3's Admission Record, dated 09/18/2025, showed R3 moved into the facility on [redacted]/2025.

Record review of R4's Admission Record, dated 09/26/2025, showed R4 moved into the facility on [redacted]/2024.

On 09/18/2025 at 1:04 PM, the Department requested to review R3's signed Medicaid policy.

In an interview on 09/18/2025 at 1:32 PM, Staff A, Administrator, stated they did not have a signed Medicaid policy completed for R3. The Department requested to review R4's signed Medicaid policy and Staff A stated it was not completed and that they were responsible for having the older residents sign a Medicaid policy.

This is an uncorrected deficiency previously cited on 07/23/2025.

Plan/Attestation Statement

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

Kari Southard
Administrator (or Representative)

10/19/25
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete ongoing assessments focused on residents identified problems for 2 of 3 sampled residents (Resident 3 [R3] and Resident 1 [R1]). This failure placed R3 and R1 at risk for unmet care needs by staff unaware of the most recent changes in care and service needs for the residents and at risk of injury or medical complications.

Findings included...

Record review of the facility's policy and procedure, "Change in Resident Condition in

On 09/18/2025 at 1:04 PM, the Department requested to review R3's signed Medicaid policy.

In an interview on 09/18/2025 at 1:32 PM, Staff A, Administrator, stated they did not have a signed Medicaid policy completed for R3. The Department requested to review R4's signed Medicaid policy and Staff A stated it was not completed and that they were responsible for having the older residents sign a Medicaid policy.

This is an uncorrected deficiency previously cited on 07/23/2025.

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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(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete ongoing assessments focused on residents identified problems for 2 of 3 sampled residents (Resident 3 [R3] and Resident 1 [R1]). This failure placed R3 and R1 at risk for unmet care needs by staff unaware of the most recent changes in care and service needs for the residents and at risk of injury or medical complications.

Findings included…

Record review of the facility's policy and procedure, "Change in Resident Condition in

Dementia Care", undated, showed the policy ensured residents assessments were completed timely, documented, communicated and interventions implemented to maintain the highest possible quality of care. Upon any noticeable changes in resident's condition, the nurse should conduct an assessment to determine the severity of the change.

Record review of the facility's policy and procedure, "Assessment of Residents Moving into Dementia Care", undated, showed the policy was to ensure a comprehensive and person-centered assessment of individuals that were moving into the facility to ensure that their needs were met in a supportive and respectful manor. The facility was to ensure the facility and well-being of the residents by providing a thorough assessment of each resident's needs, the facility would ensure all assessments and care plans comply with local, state, and federal regulations. The facility would maintain accurate and up-to-date records for each resident.

Record review of Food Drug Administration website article, "A guide to bed safety", dated "04/2010", showed patients who have problems with memory, sleep, incontinence, pain, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Potential risks of [redacted] included strangling, suffocating, bodily injury, or death when a patient or part of their body were caught between the [redacted] or between the [redacted] and mattress. Most serious injuries from falls when patient climb over [redacted] The best way of reducing the risk when [redacted] were used included on-going assessment of the patient's physical and mental status and closely monitor high-risk patients.

R3

Record review of R3's Admission Record, dated [redacted]/2025, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R3's Service Plan Report, undated, that was signed by the caregivers on 09/17/2025 and 09/18/2025, showed R3 demonstrated inappropriate judgement, behavior, and ability to function in social settings. On 05/07/2025 it was initiated that R3 requires a controlled carbohydrate diet with a pureed (food that is blended smooth) texture, and nectar (liquids that are thicker than honey) thick liquids. R3 had swallowing difficulties that required them to have a mechanically altered diet. Care staff were to report any changes in ability to eat or drink.

Record review of R3's Provider Order, dated 07/10/2025, showed R3's diet changed to consistent carbohydrate diet mechanical (regular food that are chopped up and easy to chew and swallow) soft diet, and thin liquids.

Record review of R3's progress note, dated 09/07/2025 at 11:39 PM, showed R3 was drinking coffee that night when R3 took a drink and choked. R3 continued to choke until R3 threw up all the coffee that was drank on themselves and their bedroom floor.

Record review of R3's progress note, dated 09/12/2025 at 5:37 PM, showed R3 had coffee with dinner and choked on it. Staff had to direct R3 to spit out the coffee but refused.

Record review of R3's progress note, dated 09/14/2025 at 2:00 PM, showed R3 received coffee that they choked on. Staff had to direct R3 to spit the coffee out, but R3 refused.

Record review of R3's progress notes, dated 09/07/2025 through 09/18/2025, showed there was no focused assessment completed by the nurse related to R3's choking and recent diet change to thin liquids and mechanical soft diet.

In an interview on 09/18/2025 at 3:20 PM, Staff B, Director of Nursing, stated they would not complete a focused assessment on any residents that had a diet upgrade change unless there were concerns. Staff B stated they had not completed a focused assessment on R1 since their diet was upgraded from puree texture to mechanical soft texture and nectar thick liquids to thin liquids. Staff B stated they were unaware and not notified by the caregivers and medication technicians that R1 was having difficulties with drinking coffee. Staff B stated they try to read the residents' progress notes daily but do not always get around and review them. Staff B acknowledged that R1 did not have a recent swallow evaluation prior to the diet change or since the diet was changed.

R1

Record review of R1's Admission Record, dated 09/26/2025, showed R1 moved into the facility on [redacted]/2025 with multiple diagnoses that included [redacted], and [redacted].

Record review of R1's Service Plan Report, undated, showed R1 was unable to follow directions, had a history of harming self and others, reluctant to care, at risk for falls, and wanders aimlessly independently. R1's bed was to be in low position and requires reminders to call for assistance. R1 was unable to take instructions or carry out the instructions or tasks. R1 demonstrates inappropriate judgement and behavior related to safety related to their severe dementia with significant short and long-term memory loss. The service plan did not show that R1 required the use of any assistive [redacted] devices on their bed.

Record review on 09/19/2025 at 2:31 PM, of the facility's electronic record system, showed R1 did not have an assistive device [redacted] assessment completed.

In an observation and interview on 09/18/2025 at 2:36 PM, inside R1's room on both sides of the upper part of their bed were [redacted] that were up. Staff C, Nursing Caregiver, stated the caregivers always have the [redacted] up when R1 was in bed.

On 09/18/2025 at 2:57 Pm, R1's assistive device for [redacted] assessment was requested from Staff B, Director of Nursing. Staff B stated they were unaware that R1 had [redacted] on their bed and there was not an assistive device [redacted] assessment completed.

This is an uncorrected deficiency previously cited on 07/23/2025.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) 11/5/25.

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

Kari Sutherland
Administrator (or Representative)

10/19/25
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 ensure the facility had a clinical laboratory improvement amendments (CLIA) waiver for 1 of 1 facility. This failure placed Resident 3 [R3] and all other residents at risks of improper laboratory testing.

Findings included:

Washington Administrative Code (WAC) 246-338-010 "Definitions. For the purposes of this chapter, the following words and phrases have these meanings unless the context

Record review on 09/18/2025 at 2:31 PM, of the facility's electronic record system, showed R1 did not have an assistive device [redacted] assessment completed.

In an observation and interview on 09/18/2025 at 2:36 PM, inside R1's room on both sides of the upper part of their bed were [redacted] that were up. Staff C, Nursing Caregiver, stated the caregivers always have the [redacted] up when R1 was in bed.

On 09/18/2025 at 2:57 Pm, R1's assistive device for [redacted] assessment was requested from Staff B, Director of Nursing. Staff B stated they were unaware that R1 had [redacted] on their bed and there was not an assistive device [redacted] assessment completed.

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Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2040 Other requirements.

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the facility had a clinical laboratory improvement amendments (CLIA) waiver for 1 of 1 facility. This failure placed Resident 3 [R3] and all other residents at risks of improper laboratory testing.

Findings Included…

Washington Administrative Code (WAC) 246-338-010 "Definitions. For the purposes of this chapter, the following words and phrases have these meanings unless the context

clearly indicates otherwise… (25) "Medical test site" or "test site" means any facility or site, public or private, which analyzes materials derived from the human body for the purposes of health care, treatment, or screening. A medical test site does not mean: (a) A facility or site, including a residence, where a test approved for home use by the Federal Food and Drug Administration is used by an individual to test himself or herself without direct super vision or guidance by another and where this test is not part of a commercial transaction…

WAC 246-338-020 “Licensure—Types of medical test site licenses. After July 1, 1990, any person advertising, operating, managing, owning, conducting, opening, or maintaining a medical test site must first obtain a license from the department. License types are described in Table 020-1. (1) Certificate of waiver. Applicable if the medical test site performs only the tests classified as waived.”

Record review of the Washington State Department of Health website article, “Medical Test Sites”, undated, under the section “mission”, showed the states was to ensure that the public received accurate and reliable clinical laboratory services and test results by monitoring and evaluating medical test sites for compliance with minimal standards of quality assurance for clinical laboratory testing. The CLIA required certification of all sites that performed clinical laboratory testing.

Record review of the Centers for Disease Control and Prevention (CDC) website article, “Clinical Laboratory Improvement Amendments”, dated 09/11/2024, showed CDC was in partnership with centers for medical and Medicaid services (CMA) and the Food and Drug Administration (FDA), supports the CLIA program and clinical laboratory quality. The CLIA of 1988 regulates all United States facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease.

In an interview on 09/18/2025 at 1:27 PM, Staff A, Administrator, stated the facility did not have a CLIA certificate waiver and only had a copy of the filled out application to obtain the CLIA certificate without any documentation to show that it was sent to the Department of Health for submission.

Record review of an email sent to the Department on 09/19/2025 at 6:03 PM, showed the check for the CLIA waiver had not cleared the owners account.

Record review on 09/24/2025 at 10:01 AM, on the Quality certification and oversight reports database, showed there were no CLIA laboratories for the facility name.

Record review of Resident 3’s (R3) Medication Administration Record, dated 09/06/2025 through 09/18/2025, showed the facility medication technicians were to check R3’s blood sugar two times daily for R3’s type 2 diabetes (medical condition that the body is unable to regular high blood sugar levels in a normal level).

In an interview on 09/18/2025 at 2:39 PM, Staff E, Nursing Medication Technician, stated the medication technicians do check residents blood sugars if there was an physician order. Staff E stated they checked R3’s blood sugar two times a daily.

As of 09/24/2025 at 5:00 PM, a copy of the facility’s CLIA certificate waiver was not provided.

This is an uncorrected deficiency previously cited on 07/23/2025.

Plan/Attestation Statement

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

Kari Sutherland — Administrator (or Representative)

10/19/25 — 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:

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received medications as ordered for 2 of 3 residents (Resident 1 [R1] and Resident 3 [R3]). This failure resulted in R1 and R3 not receiving medications as ordered and contributed to both residents experiencing increased behaviors and agitation that disrupted their daily living needs and placed the staff and other residents at risk of injury or psychological harm.

Findings included...

Record review of the facility's policy and procedure, "medication services", undated, showed the policy established clear guidelines and procedures for the administration of resident's medication in the assisted living facility to ensure safe, accurate, and effective medication management for all residents. The Director of Nursing oversees the medication management program and ensures compliance with policies, regulations, and medication administration process.

Plan/Attestation Statement

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Administrator (or Representative) Date

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(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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received medications as ordered for 2 of 3 residents (Resident 1 [R1] and Resident 3 [R3]). This failure resulted in R1 and R3 not receiving medications as ordered and contributed to both residents experiencing increased behaviors and agitation that disrupted their daily living needs and placed the staff and other residents at risk of injury or psychological harm.

Findings included…

Record review of the facility's policy and procedure, "medication services", undated, showed the policy established clear guidelines and procedures for the administration of resident's medication in the assisted living facility to ensure safe, accurate, and effective medication management for all residents. The Director of Nursing oversees the medication management program and ensures compliance with policies, regulations, and medication administration process.

Record review of the facility plan of correction, signed 07/28/2025, showed that Staff A, Administrator, attested that the facility would be back in compliance with WAC 388-78A-2210 by 09/06/2025.

R3

Record review of R3's Admission Record, dated [redacted]/2025, revealed an admission date on [redacted]/2025 with multiple medical diagnoses that included [redacted], and [redacted].

Record review of R3's Service Plan Report, dated 09/17/2025, documented R3 demonstrated inappropriate judgement in social settings. R3 experienced pain and behaviors that included anxiousness, history of self-harming, hitting staff during medication administration, and agitation that required the staff to administer R3 medications per physician orders.

Record review of R3's Medication Administration Record (MAR), dated 09/01/2025 through 09/18/2025, showed R3 have the following medications orders that included:
- Amlodipine (prescribed medication to help lower high blood pressure) given daily.
- Atorvastatin Calcium (prescribed medication to reduce cholesterol levels) given daily.
- Escitalopram oxalate (prescribed medication to help with sad depressed moods) given daily.
- Famotidine (medication to help reduce acid in the stomach given daily.
- Farxiga (prescribed medication to help lower high blood sugar levels) given daily
- Insulin glargine (injected prescribed medication to help lower high blood sugar levels) injection given daily.
- Losartan Potassium (prescribed medication to help lower blood pressure) daily.
- Risperidone (a prescribed medication to help treat agitation) given two times daily.
- Trazadone (prescribed medication to help treat sadness and depression) given daily.
- Carvedilol (prescribed medication to help lower high blood pressure) given two times daily
- Gabapentin (prescribed medication to help treat long term pain) given two times daily
- Metformin (prescribed medication to help lower high blood sugar levels), given two times daily

Review of R3's MAR, dated 09/06/2025 through 09/18/2025, documented R3 did not receive their Atorvastatin Calcium and trazadone for 6 days, Risperidone, Carvedilol, and Gabapentin one or both doses of medications were not administered for 10 days, and amlodipine, escitalopram oxalate, famotidine, losartan potassium, and metformin were not administered 8 days. All the missing doses were documented that resident was sleeping.

Record review of R3's progress note, dated 09/09/2025 at 5:24 PM, documented that R3 was wanting to leave the facility with the staff and was unable to be redirected that required R3 to be administered an as needed antianxiety medication.

Record review of R3's progress note, dated 09/13/2025 at 3:21 PM, documented R3 was displayed anger and frustration, when R3 pushed another resident, wandered into the other resident's room, and continued to try and leave the facility after they were given an as needed antianxiety medication.

Record review of R3's progress note, dated 09/15/2025 at 11:12 PM, documented R3 pushed another resident out of their room. At 4:21 PM, R3 was upset and wanted to leave the facility and was not redirectable.

Review of R3's progress notes, dated 09/08/2025 through 09/18/2025, showed there was no documentation of the attempts to give R3 their medication or that the physician was notified that R3 missed their medications.

R1

Record review of R1's Admission Record, dated 09/26/2025, showed R1 moved into the facility on /2025 with multiple diagnoses that included , and

Record review of R1's Service Plan Report, undated, showed R1 was unable to follow directions, had a history of harming self and others, reluctant to care, at risk for falls, and wanders aimlessly independently. R1's bed was to be in low position and R1 required reminders to call for assistance. R1 was unable to take instructions or carry out the instructions or tasks. R1 demonstrated inappropriate judgement and behavior related to safety related to their severe dementia with significant short and long-term memory loss.

Record review of R1's MAR, dated 09/01/2025 through 09/18/2025, showed R1 had the following medication orders:
- Mirtazapine (prescribed medication to help with sad mood, behaviors, and appetite) taken daily.
- Senna (medication to help soften bowel movements) taken daily.
- Olanzapine (a prescribed medication to help with behaviors and agitation) taken two times daily.

Review of R1's MAR administrations, dated 09/06/2025 through 09/18/2025, showed R1'

s Olanzapine one or both doses were not administered eight days and mirtazapine and senna were not administered seven days. All the missed doses were documented that R1 was sleeping.

Record review of R1's progress note, dated 09/07/2025 at 11:36 AM, showed R1 was entering resident's rooms and hitting and pushing at staff members. R1 required as needed medication to help reduce R1's agitation. At 5:50 PM, R1 was yelling and hitting at staff and required an as needed medication to help reduce R1's agitation.

Record review of R1's progress note, dated 09/10/2025 at 7:37 AM, showed R1 woke up yelling and hitting at staff during personal care. At 5:02 PM, R1 was yelling at other residents, slapping staff, and unable to be redirected that required staff to administer an as needed antianxiety medication.

Record review of R1's progress note, dated 09/15/2025 at 9:37 AM, showed was going in and out of other resident's rooms, yelling and pushing staff away.

Review of R1's progress notes, dated 09/15/2025 at 9:39 AM and 09/18/2025 at 7:33 AM, showed R1 was experiencing constipation for three days and required as needed medication.

In an interview on 09/18/2025 at 2:57 PM, Staff B, Director of Nursing, stated R1 was being discharged from hospices service in one week and R3 was not on hospice services. Staff B stated all residents that were on hospice services when their medications were due to be administered and the resident was sleeping, staff were to not wake them up. Staff B stated the medication technicians should try at least once to wake the resident up to administer the medication and document their attempts and then notify the resident's physician. Staff B stated the resident on hospice services did not have a physician order to not give the medication if they were sleeping or it was not care planned. Staff B was unsure if the facility had a policy about residents missing or not administered their medications and that R1 and R3's physicians were not notified that they missed multiple doses of their medications related to them sleeping. At 3:42 PM, Staff A, Administrator stated the facility did not have a policy on when a resident's medications were missed.

This is an uncorrected deficiency previously cited on 07/23/2025 for subsection 388-78a-2210-1b.

Statement of Deficiencies	License #: 2685	Compliance Determination #65812
Plan of Correction	Wellspring Centralia LLC	Completion Date
Page 14 of 14	Licensee: Wellspring Centralia LLC	10/01/2025

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) 11/15/25.

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

Kari Sutherland — Administrator (or Representative)

10/19/25 — Date

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 07/08/2025 and 07/16/2025 of:

Wellspring Centralia LLC
1215 S Tower Ave
Centralia, WA 98531

The following sample was selected for review during the unannounced on-site visit: 4 of 12 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2685	Compliance Determination # 62204
Plan of Correction	Wellspring Centralia LLC	Completion Date
Page 2 of 28	Licensee: Wellspring Centralia LLC	07/23/2025

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.

Clinton Fridley
Residential Care Services

07/25/2025
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.

Administrator (or Representative)

7/28/25
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the residents Service Agreement (facility's version of the negotiated service plan) was followed and implemented for 1 of 4 sampled memory care residents (Resident 3 [R3]). This failure placed R3 at risk for medical complications, decreased quality of life, and possible hospitalization.

Findings included...

Record review of the facility's policy titled, "change of service for resident", undated, showed the policy applied to all staff involved in assessment, planning, and delivery of services to the residents at the facility. Under the section, procedure implementation, showed interdisciplinary team shall implement the changes in services according to the resident's care plan and individualized needs.

Record review of R3's Admission Record, dated [redacted] 2025, showed R3 moved into the facility on [redacted] 2025 with multiple medical diagnoses that included [redacted] and [redacted]

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-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that the residents Service Agreement (facility's version of the negotiated service plan) was followed and implemented for 1 of 4 sampled memory care residents (Resident 3 [R3]). This failure placed R3 at risk for medical complications, decreased quality of life, and possible hospitalization.

Findings included…

Record review of the facility's policy titled, "change of service for resident", undated, showed the policy applied to all staff involved in assessment, planning, and delivery of services to the residents at the facility. Under the section, procedure implementation, showed interdisciplinary team shall implement the changes in services according to the resident's care plan and individualized needs.

Record review of R3's Admission Record, dated [redacted]/2025, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] and [redacted].

Record review of R3's Service Plan Report, dated [redacted]/2025, showed R3 demonstrated inappropriate judgement, behavior, and ability to function in social settings. R3 requires a controlled carbohydrate diet with a pureed (food that is blended smooth) texture, and nectar (liquids that are thicker than honey) thick liquids. R3 had swallowing difficulties that required them to have a mechanically altered diet. Care staff were to report any changes in ability to eat or drink.

Record review of R3's diet order communication, dated 06/02/2025, showed R3 was on a pureed consistency diet, with nectar thick liquids. The document was signed and dated by Staff H, Director of Nursing.

In an interview on 07/09/2025 at 12:37 PM, Staff J, Dietary Manager, stated there were no current residents that required puree diet or thickened liquids.

On 07/09/2025 at 12:55 PM, R3 was observed sitting at a dining room table eating a plate with whole cooked carrot cubes and whole peas, beef and rice casserole, and a whole dinner roll with a cup of thin water. None of the food was pureed or drinks were thickened.

In an interview on 07/10/2025 at 11:05 AM, Staff I, Nursing, stated R3 drank thin liquids, and ate meals that were cut up. Staff I stated at times.

In an observation on 07/10/2025 at 12:39 PM, R3 was observed eating whole cauliflower that had been cooked, whole rice pilaf, and a bowl of soup. At 12:41 PM Staff A, Administrator, had Staff H on the phone that stated R3 was to be on puree diet and nectar thick liquids as it showed on R3's service plan. At 12:52 PM, Staff K, Dietary, told Staff A that R3 was on a regular diet with thin liquids. Staff K stated the facility did not have any residents that received puree diet or required thickened liquids. Staff K showed Staff A the list of residents with their current diets that were posted up in the kitchen. R3 was not listed on the list of residents or R3's diet.

In an interview on 07/10/2025 at 12:57 PM, Staff I stated R3 does often need to clear their throat or coughs after they drank thin liquids. Staff I stated R3 drank their coffee with two creamers every morning along with juice and water during their meals.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/6/25

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

Kari Scotherland
Administrator (or Representative)

7/28/25
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.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

(c) The assisted living facility is able to fully comply with such directions.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 2 of 4 residents (Resident 3 [R3] and Resident 4 [R4]) refused their medication. This failure placed R3 and R4 at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included...

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

(c) The assisted living facility is able to fully comply with such directions.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify the physician when 2 of 4 residents (Resident 3 [R3] and Resident 4 [R4]) refused their medication. This failure placed R3 and R4 at risk for medical complications due to the physician being unable to evaluate the significance of the resident not getting their medication and provide instructions.

Findings included…

Record review of the facility's policy and procedure titled, "medication refusal", undated, showed the policy was to ensure that appropriate response, documentation, and follow-up were completed when a resident refused to take a prescribed medication. When a resident refused their medication staff were to assess the situation, take appropriate steps to ensure the residents well-being, included documentation and communication with the healthcare team. Staff were to approach the resident on multiple occasions to take their medication. If the resident continued to refuse, the facility nurse for further assessment and action. On the residents medication administration record and progress notes, there would be documentation of the medication that was refused, the reason why or behavior, any interventions that were attempted, any symptoms or health changes, and communication with the physician or family. For critical medication or frequent refusals, the residents provider was to be notified and request alternative forms or review of medication regimen if refusal is ongoing. The residents power of attorney, guardian, or family were to notified if refusal could affect health or is part of a pattern.

R3

Record review of R3's Service Plan Report, undated, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted] The service plan showed R3 required assistance with medication administration, specialty preparation, and was on registered nurse delegated services. R3 demonstrated inappropriate judgement, behavior, and ability to function in social settings.

Record review of R3' medication administration record (MAR), dated [redacted]/2025 through 06/30/2025, showed on 06/22/2025 R3 refused their amlodipine (medication to help lower high blood pressure), escitalopram (a prescribed medication to help with sad mood and depression), famotidine (a prescribed medication to help lower acid in the stomach and reduce reflux), farxiga (prescribed medication to help lower high blood sugars), glargine insulin (a prescribed injected medication to help lower high blood sugars throughout a long period of time), losartan potassium (a prescribed medication to help lower high blood pressure), metformin (a prescribed medication to help manage blood sugar levels when a person has diabetes), gabapentin (a prescribed medication to help with pain), carvedilol (a prescribed medication to help lower high blood pressure), docusate sodium (a prescribed medication to help with having routine bowel movements), and their blood sugar check. There were no notes documented of the actions taken, reason why the medication was refused or if any behaviors, any interventions attempted, and any communication with the facility nurse, resident's physician or responsibly party.

Record review of R3's progress note, dated 06/22/2025 at 9:13 AM, showed R3 was sleeping, and staff member attempted to get the residents vitals, blood sugar reading, and administer medication a couple of times with R3 each time shouting "no" at staff and did not appear happy. There was no documentation that the facility nurse was notified, the resident's physician, or the residents responsible party.

Record review of R3's progress notes, dated 06/22/2025 through 06/24/2025, showed there were no progress notes on that day documented by Staff H, Director of Nursing, that showed the resident was evaluated for refusing their medications.

Record review of R3's MAR, dated 07/01/2025 through 07/09/2025, showed on 07/08/2025, R3 refused their amlodipine, escitalopram, blood sugar check, calcium with vitamin D (a prescribed medication to help increase calcium and vitamin d levels in the body for bone health), docusate sodium, gabapentin, metformin, carvedilol, risperidone (a prescribed medication to help reduce outbursts, behaviors, and decrease psychosis), losartan potassium, glargine insulin injection, famotidine, and farxiga. R3's atorvastatin (a prescribed medication to help lower high cholesterol levels to prevent heart diseases), trazadone (a prescribed medication to help with sleep and mood), carvedilol, docusate sodium, calcium with vitamin D, and gabapentin were not administered related to R3 sleeping on 06/16/2025, 06/23/2025, and 06/25/2025. There were no notes documented of the actions taken for all missed doses, reason why the medication was refused or if any behaviors, any interventions attempted, and any communication with the facility nurse, resident's physician or responsibly party.

Record review of R3's progress notes dated 07/08/2025 through 07/10/2025, the progress note on 07/08/2025 at 4:33 PM showed, that the medication technician attempted to administer R3's metformin and R3 declined. There was no documentation that Staff H was notified or R3's physician for any of the missed doses. There was no other documentation that showed Staff H had evaluated R3 after they refused their medication on 07/08/2025 and when R3 was not given their medication because they were sleeping.

R4

Record review of R4's Service Plan Report, undated, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted], and [redacted]. The service plan showed R4 was oriented and able to recall

some information and was confused and agitated at times. R4 had moderate dementia with significant short-term memory and possible long-term memory loss. R4 required medication administration that required RN delegation services. There was no documentation under the medication management or behavior sections that showed R4 refused their medications.

Record review of R4's MAR, dated 05/01/2025 through 05/31/2025, showed R4 had an order for nystatin external cream (a medicated cream that is applied to the skin to treat fungal infection) two times daily. Review of the administrations showed R4 refused to have the cream administered 42 of 60 administration times. R4 had an order for Lidocaine external patch to be applied to their lower back every morning. Review of the administrations showed R4 refused their patch to be applied 20 of 30 administrations. There were no notes documented about the refused medications, interventions attempted, resident physician or the facility nurse being notified.

Record review of R4's MAR, dated 06/01/2025 through 06/30/2025, showed R4's lidocaine patch was refused to be administered 9 of 30 administrations. On 06/21/2025 R4 was sleeping, and the lidocaine patch was not administered. There were no notes on the MAR that showed the interventions that were taken, the reason why, and that the residents physician or that Staff H had been informed about the refusals. R4 had an order for levothyroxine sodium daily in the morning. Review of the administrations showed on three days R4 was not administered their levothyroxine because they were sleeping.

Record review of R4's MAR, dated 07/01/2025 through 07/10/2025, showed R4's medication empagliflozin (a prescribed medication to help treat diabetes and lower high blood sugar levels). R4 was not administered their empagliflozin, pantoprazole (prescribed medication to help reduce acid in the stomach and reflux), Eliquis (prescribed medication to help thin the blood and prevent blood clots), gabapentin, olanzapine (prescribed medication to help with behaviors and psychosis), potassium chloride (prescribed medication to help replace potassium in the blood), quetiapine fumarate (prescribed medication to help treat behaviors and psychosis), torsemide (prescribed medication to help reduce fluid retention from the hearts in ability to pump the blood in the body), and levothyroxine medications on 07/04/2025 and 07/10/2025 as they were sleeping. R4's lidocaine patch administrations showed R4 either refused or was sleeping and was not administered their patch 8 of 10 days. R4's nystatin external cream was either refused or not administered related to R4 sleeping 16 of 17 doses administered. There were no notes on the MAR for any of the missed doses that showed R4's physician was notified they did not get their medications.

Record review of R4's progress notes, dated 05/01/2025 through 07/09/2025, showed on 05/05/2025 at 11:03 AM, Staff H documented that R4's yeast rash on their groin was resolved and the hospice provider was faxed to get the medication discontinued. The next follow up note was on 06/27/2025 at 9:10 AM, documented by Staff H that showed yeast rash was resolving in the groin areas. Medication technician faxed hospice to discontinue the cream or change to as needed. There was no other documentation that MD was notified of the missed doses of their nystatin cream until 07/09/2025 when the medication was discontinued. There was no documentation that the resident's physician

was notified about the other medication that was refused and missed from sleeping.

Record review on 07/10/2025 at 3:00 PM of R4's and R3's hard medical charts showed there were no physician notifications that showed the resident refused or missed their medication from sleeping.

In an interview on 07/09/2025 at 1:42 PM, Staff M, Nursing, stated they would progress note the medication was refused or missed and what they did to try and get the resident to take the mediation. Staff M stated they would try to give the medication at least two times and then let Staff H and Staff A know that the residents refused or missed their medication. Staff M stated they would not notify the residents physician if they refused their medication.

In an interview on 07/10/2025 at 10:00 AM, Staff A, Administrator, stated they would notify the residents physician if they refused their medication, unless they were on hospice services then they would notify hospice and if they refused their medication repeated then they would notify the hospice resident's physician of the refused medications. Staff A stated they believed the residents had a standing order upon admission to the facility that stated when the resident's physician was to be notified.

On 07/15/2025 at 10:44 AM, the facility was requested to send in any documentation for any of the concerns expressed during the preliminary exit that was on 07/10/2025 at 1:22 PM by 07/16/2025 at 5:00 PM.

As of 07/18/2025 at 5:30 PM, no additional documentation was provided about the residents that refused or missed their medication and their physicians were notified.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/5/25~~ 9/10/25

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

Kara Sutherland
Administrator (or Representative)

7/28/25
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.

was notified about the other medication that was refused and missed from sleeping.

Record review on 07/10/2025 at 3:00 PM, of R4's and R3's hard medical charts showed there were no physician notifications that showed the resident refused or missed their medication from sleeping.

In an interview on 07/09/2025 at 1:42 PM, Staff M, Nursing, stated they would progress note the medication was refused or missed and what they did to try and get the resident to take the mediation. Staff M stated they would try to give the medication at least two times and then let Staff H and Staff A know that the residents refused or missed their medication. Staff M stated they would not notify the residents physician if they refused their medication.

In an interview on 07/10/2025 at 10:00 AM, Staff A, Administrator, stated they would notify the residents physician if they refused their medication, unless they were on hospice services then they would notify hospice and if they refused their medication repeated then they would notify the hospice resident's physician of the refused medications. Staff A stated they believed the residents had a standing order upon admission to the facility that stated when the resident's physician was to be notified.

On 07/15/2025 at 10:44 AM, the facility was requested to send in any documentation for any of the concerns expressed during the preliminary exit that was on 07/10/2025 at 1:22 PM by 07/16/2025 at 5:00 PM.

As of 07/16/2025 at 5:30 PM, no additional documentation was provided about the residents that refused or missed their medication and their physicians were notified.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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 3 of 4 sampled residents (Resident 1 [R1], Resident 3 [R3], and Resident 4 [R4]) medications were available to be administered. This failure resulted in R1, R3, and R4 not receiving their medications as ordered, and placed residents at risk for unmet care needs and medical complications associated with not receiving medications as ordered.

Findings included…

R1

Record review of R1's Service Plan Report, undated, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted]. R1 required assistance with medication administration, ordering of medication and communication with their pharmacy from staff. R1 required registered nurse delegated services for their medication administration.

Record review of R1's Medication Administration Record (MAR), dated 07/01/2025 through 07/08/2025, showed R1 had an order for amlodipine besylate (a prescribed medication to help lower high blood pressure). R1's amlodipine was not available for administration from 07/04/2025 through 07/08/2025.

Record review of R1's progress notes, dated 07/01/2025 through 07/09/2025 showed R1's physician was faxed regarding a need for a new prescription for their amlodipine. There was no documentation that R1's physician was notified they were not receiving the medication as it was not available and a request for alternative medication or temporary hold. There was no documentation on R1's response or condition to not getting the amlodipine or evaluating R1's blood pressure. There was no documentation to show that R1's power of attorney was notified that they were not receiving their amlodipine medication.

R3

Record review of R3's Service Plan Report, undated, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted]

[redacted]. The service plan showed R3 required assistance with medication administration, ordering of medications, communication with R3's pharmacy, special preparation, and required registered nurse delegated services for their medication administration. R3 used a non-contracted pharmacy for their medication management.

Record review of R3's MAR, dated 06/01/2025 through 06/30/2025, showed R3 had an order for farxiga (prescribed medication to help treat diabetes and lower high blood sugars). R3's farxiga was not available for administration on 06/08/2025 through 06/16/2025. R3 had an order for carvedilol (prescribed medication to help treat high blood pressure) that was to be administered two times daily. R3 did not receive their carvedilol in the morning on 06/13/2025 and 06/16/2025 as it was not available for administration. R3's carvedilol was not available for administration in the evening on 06/13/2025 through 06/15/2025. R3 had an order for metformin (prescribed medication to help treat diabetes and lower high blood sugar levels) that was to be administered two times daily. R3's metformin was not available for administration in the morning on 06/09/2025 through 06/13/2025 and in the evening was not available 06/11/2025 through 06/13/2025. R3 had an order for calcium with vitamin D (supplement to help increase calcium and vitamin D levels in the body for bone health) that was to be administered two times daily. R3's calcium with vitamin D was not available for administration for 12 days on 06/16/2025 through 06/27/2025 for a total of 22 doses.

Record review of R3's progress notes dated 06/01/2025 through 06/30/2025, showed there were progress notes on 06/09/2025 that the facility was waiting on the physician refills. There was no documentation to show that the physician was notified that R3 was out of their medication and had not received them. There was no documentation on how R3 was adjusting with not getting their medications or that R3's power of attorney was notified.

R4

Record review of R4's Service Plan Report, undated, showed R4 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted], and [redacted]. The service plan showed R4 had moderate dementia with significant short-term memory and possible long-term memory loss. R4 required staff assistance with medication administration, ordering of medications, communication with pharmacy. All R4's medication administrations required registered nurse delegation services.

Record review of R4's MAR, dated 05/01/2025 through 05/31/2025, showed R4 had an order for fluticasone-umeclidin-vilant inhaer (prescribed medication to help improve breathing and reduce symptoms related to COPD). R4's inhaler was not available for administration on 05/26/2025through 05/31/2025.

Record review of R4's MAR, dated 06/01/2025 through 06/30/2025, showed R4's fluticasone-umeclidin-vilant inhaer was not available for administration on 06/01/2025

through 06/03/2025.

Record review of R4's progress notes, dated 05/01/2025 through 06/30/2025, showed on 05/25/2025at 6:13 PM, the pharmacy was waiting on a refill order for R4's inhaler as it was out. On 05/29/2025 at 9:32 AM the hospice provided was called requesting urgent refill of R4's inhaler. There was no documentation that R4's physician was called and notified that R4 was out of their inhaler and was receiving it until eight days of not receiving the medication. There was no documentation as to how R4's condition or response was of not receiving the inhaler.

In an interview on 07/09/2025 at 1:42 PM, Staff M, Nursing, stated they were to look for the residents' medication in the medication cart and medication room if the medication was found to not be available for administration. Staff M stated they would document on the MAR "code 11" as not available. The medication technician on shift was to call the pharmacy and the document it and pass on to the next shift for follow up. Staff M stated they were to reorder medications from the pharmacy five days prior to the medication running out. Staff M stated they were to notify the physician by fax at least on the initial dose of medication that was missed.

In an interview on 07/10/2025 at 10:00 AM, Staff A, Administrator, stated the medication technicians were to contact the resident's pharmacy to inquire about the medication that was not available in the facility for administration. The call was to be documented in the progress notes and then the pharmacy was to contact the resident's physician. Staff A stated Staff H and themselves read the residents progress notes and will call the residents pharmacy for follow up and when the medication would be delivered.

On 07/15/2025 at 10:44 AM, the facility was requested to send in any documentation for any of the concerns expressed during the preliminary exit that was on 07/10/2025 at 1:22 PM by 07/16/2025 at 5:00 PM.

As of 07/16/2025 at 5:30 PM, no additional documentation was provided about the residents and their medication not being available and their physicians were notified.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/6/25

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

Kari Southwood
Administrator (or Representative)

7/28/25
Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 6 of 6 sampled Staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) received their first and second Tuberculosis (infectious bacterial disease of the lungs) skin test within the required time. This failure placed 12 of 12 residents at risk for exposure to Tuberculosis (TB)

Findings included...

Record review of the Centers of Disease Control document titled, "Testing for Tuberculosis: skin test", dated 01/21/2025, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed and determine if it was a positive or negative test result. Under the section titled, "two-step TB skin test", showed if someone was a healthcare worker they would have a two-step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

During an unannounced licensing inspection on 07/08/2025 at 09:56 AM, the

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

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

_____ _____

Administrator (or Representative) Date

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

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

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that 6 of 6 sampled Staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) received their first and second Tuberculosis (infectious bacterial disease of the lungs) skin test within the required time. This failure placed 12 of 12 residents at risk for exposure to Tuberculosis (TB).

Findings included...

Record review of the Centers of Disease Control document titled, “Testing for Tuberculosis: skin test”, dated 01/21/2025, showed a TB skin test required two visits with a healthcare provider. If a person received a TB skin test, they would have two visits with the healthcare provider. During the first visit, the healthcare provider would inject a small amount of TB solution just under the skin on the lower part of the inner arm. On the second visit after two or three days, the person would return to the healthcare provider and have the skin test that was injected on the inner arm observed and determine if it was a positive or negative test result. Under the section titled, “two-step TB skin test”, showed if someone was a healthcare worker they would have a two-step TB skin test. The two-step TB skin test could lower the chance that boosted reaction from an old TB infection would be misinterpreted as a recent infection. If the first-step TB skin test was classified as negative, a second-step TB skin test would be given one to three weeks after the first test was read.

During an unannounced licensing inspection on 07/08/2025 at 09:56 AM, the

Department received the requested staff documents.

Staff A

Record review of the facility's untitled and undated document that was a list of employees showed Staff A, Administrator, was hired on 03/01/2024.

Record review of Staff A's Tuberculosis skin test form, undated, showed Staff A received their first step TB skin test on 06/26/2024. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff A's employee file for review.

Staff B

Record review of the facility's untitled and undated document that was a list of employees showed Staff B, Nursing, was hired on 11/01/2024.

Record review of Staff B's Tuberculosis skin test form, undated, showed Staff B received their first step TB skin test on 12/21/2024. There was no second step TB skin test documented in Staff B's employee file for review.

Staff C

Record review of the facility's untitled and undated document that was a list of employees showed Staff C, Nursing/Housekeeping, was hired on 09/19/2024.

Record review of Staff C's Tuberculosis skin test form, undated, showed Staff C received their first step TB skin test on 03/07/2025. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff C's employee file for review.

Staff D

Record review of the facility's untitled and undated document that was a list of employees showed Staff D, Dietary, was hired on 05/18/2025.

Record review of Staff D's Tuberculosis skin test form, undated, showed Staff D received their first step TB skin test on 05/30/2025. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff D's employee file for review.

Staff E

Record review of the facility's untitled and undated document that was a list of employees showed Staff E, Nursing, was hired on 03/01/2024.

Record review of Staff E's Tuberculosis skin test form, undated, showed Staff E received their first step TB skin test on 06/27/2024. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff E's employee file for review.

Staff F

Record review of the facility's untitled and undated document that was a list of employees showed Staff F, Dietary, was hired on 03/01/2024.

Record review of Staff F's Tuberculosis skin test form, undated, showed Staff F received their first step TB skin test on 06/26/2024. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff F's employee file for review.

In an interview on 07/09/2025 at 1:09 PM, Staff G, Administrative Assistant, stated Staff H, Director of Nursing, was responsible to complete the staff's TB skin tests. At 1:23 PM, Staff A stated they had only received a one-step TB skin test after starting employment at the facility. Staff A stated the facility was to test staff for TB upon hire.

In an interview on 07/16/2025 at 1:00 PM, Staff A stated the facility did not have a TB skin testing policy and that they follow CDC guidelines.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/16/25

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

Kari Southwood — Administrator (or Representative)

7/28/25 — 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

Record review of the facility's untitled and undated document that was a list of employees showed Staff E, Nursing, was hired on 03/01/2024.

Record review of Staff E's Tuberculosis skin test form, undated, showed Staff E received their first step TB skin test on 06/27/2024. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff E's employee file for review.

Staff F

Record review of the facility's untitled and undated document that was a list of employees showed Staff F, Dietary, was hired on 03/01/2024.

Record review of Staff F's Tuberculosis skin test form, undated, showed Staff F received their first step TB skin test on 06/26/2024. There was no prior TB skin test in the last 12 months, or a second step TB skin test documented in Staff F's employee file for review.

In an interview on 07/09/2025 at 1:09 PM, Staff G, Administrative Assistant, stated Staff H, Director of Nursing, was responsible to complete the staff's TB skin tests. At 1:23 PM, Staff A stated they had only received a one-step TB skin test after starting employment at the facility. Staff A stated the facility was to test staff for TB upon hire.

In an interview on 07/16/2025 at 1:00 PM, Staff A stated the facility did not have a TB skin testing policy and that they follow CDC guidelines.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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:

(a) Orientation and safety;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide documentation on site for the facility orientation training requirements for 5 of 5 sampled staff (Staff B, Staff C, Staff D, Staff E, and Staff F). This failure placed all residents at risk of care and services being provided by untrained staff.

Findings included…

Record review of facility's untitled and undated document, that was a list of employees, documented:

- Staff B, Nursing, was hired on 11/01/2024.
- Staff C, Nursing/Housekeeping was hired on 09/19/2024.
- Staff D, Dietary, was hired on 05/18/2025.
- Staff E, Nursing, was hired on 03/01/2024.
- Staff F, Dietary, was hired on 03/01/2024.

During an unannounced licensing visit on 07/08/2025 at 09:56 AM, the facility provided Staff B, Staff C, Staff D, Staff E, and Staff F's employee files that did not have facility orientation documentation for review.

In an interview on 07/09/2025 at 1:09 PM, Staff G, Administrator Assistant, stated the facility did not have any documentation to show staff completed all areas required for the facility orientation.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/16/25

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

Kari Southard
Administrator (or Representative)

7/28/25
Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 4 of 4 sampled Residents (Resident 1[R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure placed all four residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included...

Record review of R1's Admission Record, dated 07/21/2025, showed R1 moved into the facility on [redacted]2024.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2665 Resident rights Notice Policy on accepting medicaid as a payment source. The assisted living facility must fully disclose the facility's policy on accepting medicaid payments. The policy must:

(1) Clearly state the circumstances under which the assisted living facility provides care for medicaid eligible residents and for residents who become eligible for medicaid after admission;

(2) Be provided both orally and in writing in a language that the resident understands;

(3) Be provided to prospective residents, before they are admitted to the home;

(4) Be provided to any current residents who were admitted before this requirement took effect or who did not receive copies prior to admission;

(5) Be written on a page that is separate from other documents and be written in a type font that is at least fourteen point; and

(6) Be signed and dated by the resident and be kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were provided a Medicaid Policy for 4 of 4 sampled Residents (Resident 1[R1], Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure placed all four residents and their responsible party at risk of making uninformed decisions about placement with consideration of potential changes in their financial circumstances.

Findings included…

Record review of R1's Admission Record, dated 07/21/2025, showed R1 moved into the facility on [redacted]/2024.

Record review of R2's Admission Record, dated [redacted]2025, showed R2 moved into the facility on [redacted]2025.

Record review of R3's Admission Record, dated [redacted]2025, showed R3 moved into the facility on [redacted]2025.

Record review of R4's Admission Record, dated [redacted]2025, showed R4 moved into the facility on [redacted]2024.

During an unannounced visit on 07/08/2025 at 9:56 AM, R1, R2, R3, and R4's charts were reviewed, no documentation that a Medicaid policy was provided.

In an interview on 07/08/2025 at 2:45 PM, Staff A, Administrator, stated the facility does not have a Medicaid Policy that was on a separate page other than the one that was in the facility's disclosure of service document on page eight that was with the sections about fire protection services and "bed hold" services.

In an interview on 07/10/2025 at 1:30 PM, Staff A stated the facility had to make a Medicaid policy and needed to present the document to the resident and or the resident's representative for signatures.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/16/25

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

Kari Sutherland
Administrator (or Representative)

7/28/25
Date

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

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Record review of R2's Admission Record, dated [redacted]/2025, showed R2 moved into the facility on [redacted]/2025.

Record review of R3's Admission Record, dated [redacted]/2025, showed R3 moved into the facility on [redacted]/2025.

Record review of R4's Admission Record, dated [redacted]/2025, showed R4 moved into the facility on [redacted]/2024.

During an unannounced visit on 07/08/2025 at 9:56 AM, R1, R2, R3, and R4's charts were reviewed, no documentation that a Medicaid policy was provided.

In an interview on 07/09/2025 at 2:45 PM, Staff A, Administrator, stated the facility does not have a Medicaid Policy that was on a separate page other than the one that was in the facility's disclosure of service document on page eight that was with the sections about fire protection services and "bed hold" services.

In an interview on 07/10/2025 at 1:30 PM, Staff A stated the facility had to make a Medicaid policy and needed to present the document to the resident and or the resident's representative for signatures.

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

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

_____ _____

Administrator (or Representative) Date

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

(2) Complete the negotiated service agreement for each resident using the resident's preadmission assessment, initial resident service plan, and full assessment information, within thirty days of the resident moving in;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete the Resident Service Agreement (facility's version of the Negotiated Service Agreement) within 30 days following admission to the facility for 3 of 3 sampled newly admitted residents (Resident 2 [R2], Resident 3 [R3], and Resident 4 [R4]). This failure placed all three newly admitted residents at risk of unmet care needs and a decreased quality of life.

Findings included…

Record review of the facility's policy titled, "change of service for resident", undated, showed changes in the resident's services were based on a comprehensive assessment. All changes would be documented on the resident's care plan. Development of the resident's care plan was based on the assessment. Changes in the residents services shall be reviewed and approved by the resident or their responsible party that ensures informed consent and understanding of the implications of the change.

Record review of the facility's policy and procedure, "assessment of residents moving into dementia care", undated, showed the facility would ensure all assessments and care plans comply with local, state, and federal regulations. The facility would maintain accurate and up-to-date records for each resident.

R2

Record review of R2's Admission Record, dated [redacted]/2025, showed R2 moved into the facility on [redacted]/2025.

Record review of R2's Service Plan Report (facility's version of negotiated service agreement), dated 02/20/2025, showed it was signed and dated [redacted]/2025. R2's service plan was their initial service plan, with no other service plan completed within 30 days of admission to the facility.

R3

Record review of R3's Admission Record, dated [redacted]/2025, showed R3 moved into the facility on [redacted]/2025.

Record review of R3's Service Plan Report, dated 05/07/2025, showed it was signed and dated [redacted]/2025. R3's service plan was their initial service plan, with no other service plan completed within 30 days of admission to the facility.

R4

Record review of R4's Admission Record, dated 02/25/2025, showed R4 moved into the facility on [redacted]2024

Record review of R4's Service Plan Report, dated 11/12/2024, showed it was signed and dated 11/27/2024. R4's service plan was their initial service plan, with no other service plan completed within 30 days of admission to the facility.

In an interview on 07/10/2025 at 8:54 AM, Staff A, Administrator, stated Staff H, Director of Nursing, has never completed a 30-day service agreement for new residents that are admitting to the facility.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/6/25

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

Kari Southwood
Administrator (or Representative)

7/28/25
Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues.

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete ongoing assessments focused on residents identified problems for 2 of 2 sampled resident (Resident 1 [R1] and Resident 5 [R5]). This failure placed R1 and R5 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included...

Record review of the facility's policy and procedure, "change of service for resident",

Record review of R4's Admission Record, dated 02/28/2025, showed R4 moved into the facility on [redacted]/2024.

Record review of R4's Service Plan Report, dated 11/12/2024, showed it was signed and dated 11/27/2024. R4's service plan was their initial service plan, with no other service plan completed within 30 days of admission to the facility.

In an interview on 07/10/2025 at 9:54 AM, Staff A, Administrator, stated Staff H, Director of Nursing, has never completed a 30-day service agreement for new residents that are admitting to the facility.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete ongoing assessments focused on residents identified problems for 2 of 2 sampled resident (Resident 1 [R1] and Resident 5 [R5]). This failure placed R1 and R5 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included…

Record review of the facility's policy and procedure, "change of service for resident",

undated, showed assessments should be based on the resident's health status, functional abilities, preferences, and evolving care needs.

Record review of the facility's policy and procedure, "assessment of residents moving into dementia care", undated, showed the policy was to ensure a comprehensive and person-centered assessment of individuals that were moving into the facility to ensure that their needs were met in a supportive and respectful manor. The facility was to ensure the facility and well-being of the residents by providing a thorough assessment of each resident's needs, the facility would ensure all assessments and care plans comply with local, state, and federal regulations. The facility would maintain accurate and up-to-date records for each resident.

Record review of Food Drug Administration website article, "A guide to bed safety", dated "04/2010", showed patients who have problems with memory, sleep, incontinence, pain, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Potential risks of [redacted] included strangling, suffocating, bodily injury, or death when a patient or part of their body were caught between the [redacted] or between the [redacted] and mattress. Most serious injuries from falls when patient climb over [redacted]. The best way of reducing the risk when [redacted] were used included on-going assessment of the patient's physical and mental status and closely monitor high-risk patients.

R1

Record review of R1's Service Plan Report, undated, showed R1 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted]. The service plan showed R1 required one to two staff members to assist them with transfers and mobility to ensure safety and prevent future falls. R1 demonstrates inappropriate judgement and has mild-moderate dementia with significant short-term memory and possible long-term memory loss. R1 was at risk for falls related to cognitive deficit, mental health history, poor safety awareness, and weakness in their knees. R1's service plan did not indicate that R1 used any [redacted] on their bed.

Record review of R1's assessment and service plan, dated 03/11/2025, showed R1 required assistance from one to two staff members for transfers and mobility. R1 was not always oriented and required staff assistance with orientation. R1 demonstrates inappropriate judgement and has mild-moderate dementia with significant short-term memory and possible long-term memory loss. There was no assessment or documentation that R1 required the use of the [redacted] that was on R1's bed.

In an observation and interview on 07/09/2025 at 10:39 AM, R1 had their left side of the bed up against the wall and the right side of the bed that had a [redacted]. R1 stated that

the facility staff put the [redacted] up when they were in bed to help keep them from rolling out of bed. R1 stated that they do not use the [redacted] to help roll themselves in bed, but to help keep them in bed and from falling.

R5

Record review of R5's Service Plan Report, undated, showed R5 moved into the facility on [redacted]/2024 with multiple medical diagnoses that included [redacted] and [redacted]. R5's service plan showed R5 had a history of harming self and made suicidal statements. R5 had a decrease in cognition, safety awareness, and inappropriate judgement related to safety, that resulted in multiple falls. R5 does not use their call button and attempts to transfer and ambulate without seeking assistance from staff. Interventions for reduction in falls included [redacted] on the bed (also known as [redacted]).

Record review of R5's assessment and service plan, dated 04/22/2025, showed R5's cognition was not always oriented that required staff assistance with redirection and orientation. R5 had moderate dementia with significant short-term memory and possibly long-term memory loss. R5 had a history of falls and was high risk for falls. The facility had obtained [redacted] for R5's bed to help minimize falls. There was no focused assessment if the resident was capable and remembered on how to use the [redacted] that was on their bed documented.

In an observation on 07/08/2025 at 4:00 PM, R5 was sitting in their room in their reclining chair. R5's right side of the bed was up against the wall and the left side of the upper half of the bed had a [redacted] that was up and a fall mat that was on the ground beside the bed.

In an observation on 07/10/2025 at 11:26 AM, R5's bedroom door was open and R5 was lying in bed. R5's [redacted] was engaged up with R5's lower legs hanging off the bed below the end of the [redacted]. R5's upper body was on the bed with their eyes closed.

In an interview on 07/10/2025 at 10:11 AM, Staff A, Administrator, stated Staff H, Director of Nursing, does not complete a focused assessment on residents that use [redacted] on their beds. Staff H stated they would get a physician order and then put the [redacted] on their care plan without an assessment of the residents use with the [redacted] device.

In an interview on 07/10/2025 at 11:04 AM, Staff L, Nursing, and Staff I, Nursing, stated R1 and R5 have their [redacted] up on their bed anytime they were in bed. Staff L stated R1 and R5 were both high fall risks and reason for the [redacted] that the physician had ordered.

Statement of Deficiencies	License #: 2885	Compliance Determination # 62201
Plan of Correction	Wellspring Centralia LLC	Completion Date
Page 22 of 28	Licensee: Wellspring Centralia LLC	07/23/2025

In a preliminary exit on 07/10/2025 at 1:22 PM, Staff A was informed of the concerns that there were no focused assessments on R1 and R5 ability to use the [redacted] on their bed cognitive deficits.

On 07/16/2025 at 10:44 AM, the facility was requested to send any documents by 07/16/2025 at 5:00 PM, for the areas of concerned expressed on 07/10/2025 at 1:22 PM. As of 07/16/2025 at 5:30 PM, R1 or R5's assessment of the [redacted] was not provided.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/1/25

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

Kari Sutherland
Administrator (or Representative)

7/28/25
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 ensure the facility had a clinical laboratory improvement amendments (CLIA) waiver for 1 of 1 facility. This failure placed all 12 residents at risks of improper laboratory testing.

Findings Included..

Washington Administrative Code (WAC) 246-338-010 "Definitions. For the purposes of this chapter, the following words and phrases have these meanings unless the context clearly indicates otherwise... (25) "Medical test site" or "test site" means any facility or site, public or private, which analyzes materials derived from the human body for the purposes of health care, treatment, or screening. A medical test site does not mean: (a) A facility or site, including a residence, where a test approved for home use by the Federal Food and Drug Administration is used by an individual to test himself or herself without direct supervision or guidance by another and where this test is not part of a commercial transaction ..

WAC 246-338-020 "Licensure—Types of medical test site licenses. After July 1, 1990, any person advertising, operating, managing, owning, conducting, opening, or

In a preliminary exit on 07/10/2025 at 1:22 PM, Staff A was informed of the concerns that there were no focused assessments on R1 and R5 ability to use the [redacted] on their bed cognitive deficits.

On 07/15/2025 at 10:44 AM, the facility was requested to send any documents by 07/16/2025 at 5:00 PM, for the areas of concerned expressed on 07/10/2025 at 1:22 PM. As of 07/16/2025 at 5:30 PM, R1 or R5's assessment of the [redacted] was not provided.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-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 ensure the facility had a clinical laboratory improvement amendments (CLIA) waiver for 1 of 1 facility. This failure placed all 12 residents at risks of improper laboratory testing.

Findings Included…

Washington Administrative Code (WAC) 246-338-010 "Definitions. For the purposes of this chapter, the following words and phrases have these meanings unless the context clearly indicates otherwise… (25) "Medical test site" or "test site" means any facility or site, public or private, which analyzes materials derived from the human body for the purposes of health care, treatment, or screening. A medical test site does not mean: (a) A facility or site, including a residence, where a test approved for home use by the Federal Food and Drug Administration is used by an individual to test himself or herself without direct super vision or guidance by another and where this test is not part of a commercial transaction…

WAC 246-338-020 "Licensure—Types of medical test site licenses. After July 1, 1990, any person advertising, operating, managing, owning, conducting, opening, or

maintaining a medical test site must first obtain a license from the department. License types are described in Table 020-1. (1) Certificate of waiver. Applicable if the medical test site performs only the tests classified as waived."

Record review of the Washington State Department of Health website article, "Medical Test Sites", undated, under the section "mission", showed the states was to ensure that the public received accurate and reliable clinical laboratory services and test results by monitoring and evaluating medical test sites for compliance with minimal standards of quality assurance for clinical laboratory testing. The CLIA required certification of all sites that performed clinical laboratory testing.

Record review of the Centers for Disease Control and Prevention (CDC) website article, "Clinical Laboratory Improvement Amendments", dated 09/11/2024, showed CDC was in partnership with centers for medical and Medicaid services (CMA) and the Food and Drug Administration (FDA), supports the CLIA program and clinical laboratory quality. The CLIA of 1988 regulates all United States facilities or sites that test human specimens for health assessment or to diagnose, prevent, or treat disease.
On an unannounced visit on 07/08/2025 at 10:00 AM, a copy of the facility's valid medical test site certification of waiver license/CLIA was requested. At 2:45 PM, Staff A, Administrator, was asked if they had a CLIA certificate. Staff A was unaware what the CLIA certificate was. Staff A stated Staff H, Director of Nursing, performed the residents flu (a viral infection of the respiratory system that is contagious) swab testing and COVID (also known as coronavirus a severe respiratory virus that can cause shortness of breath, loss of taste or smell, and may progress to lung infection or failure) nasal swab testing within the facility and the medication technicians checked the residents blood sugars under Registered Nurse Delegation services. As of 5:30 PM, a copy of the facility's CLIA certificate was not provided.

In an interview on 07/09/2025 at 9:00 AM, Staff A stated the facility did not have a CLIA certificate waiver.

Record review on 07/16/2025 at 9:00 AM, on the Quality certification and oversight reports database, showed there were no CLIA laboratories for the facility name.

As of 07/16/2025 at 5:00 PM, a copy of the facility's CLIA certificate waiver was not provided.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/6/25~~ 9/6/25

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

Kari Sutherland
Administrator (or Representative)

7/28/25
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

(a) Prescribed general low sodium, general diabetic, and mechanical soft food diets according to a diet manual. The assisted living facility must ensure the diet manual is:

(ii) Approved by a dietitian, and

(iii) Reviewed and updated as necessary or at least every five years.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow and implement safe food purchases and have a dietary manual complete and accessible for 1 of 1 facility kitchen area reviewed (memory care kitchen). This failure placed all memory care residents at risk of receiving food that would increase the residents exposure to food-borne illnesses and not having their nutritional needs reviewed by a registered dietician.

Findings included...

Washington Administrative Code (WAC) 246-215-03600 "Additional safeguards—Pasteurized foods, prohibited reservice, and prohibited food (FDA Food Code 3-801.11) In a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION: (2) Pasteurized EGGS or EGG PRODUCTS must be substituted for raw EGGS in the preparation of: (a) FOODS such as Caesar salad, hollandaise or Bearnaise sauce.

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

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(d) Prepare food on-site, or provide food through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC Food service;

(2) The assisted living facility must plan in writing, prepare on-site or provide through a contract with a food service establishment located in the vicinity that meets the requirements of chapter 246-215 WAC, and serve to each resident as ordered:

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This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow and implement safe food purchases and have a dietary manual complete and accessible for 1 of 1 facility kitchen area reviewed (memory care kitchen). This failure placed all memory care residents at risk of receiving food that would increase the residents exposure to food-borne illnesses and not having their nutritional needs reviewed by a registered dietician.

Findings included…

Washington Administrative Code (WAC) 246-215-03800 “Additional safeguards—Pasteurized foods, prohibited reservice, and prohibited food (FDA Food Code 3-801.11). In a FOOD ESTABLISHMENT that serves a HIGHLY SUSCEPTIBLE POPULATION: (2) Pasteurized EGGS or EGG PRODUCTS must be substituted for raw EGGS in the preparation of: (a) FOODS such as Caesar salad, hollandaise or Bearnaise sauce,

mayonnaise, meringue, eggnog, ice cream, and EGG-fortified BEVERAGES; and (b) Except as specified in subsection (6) of this section, recipes in which more than one eggs is broken and the eggs are combined. in which more than one EGG is broken and the EGGS are combined."

WAC 246-215-03312 “Preventing food and ingredient contamination— Pasteurized eggs, substitute for raw eggs for certain recipes (FDA Food Code 3-302.13). Pasteurized EGGS or EGG PRODUCTS must be substituted for raw EGGS in the preparation of FOODS such as Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and EGG-fortified BEVERAGES that are not: (1) Cooked as specified under WAC 246-215-03400 (1)(a) or (b); or (2) Included in WAC 246-215-03400(4).”
WAC 246-215-03400 “Cooking—Raw animal foods (FDA Food Code 3-401.11). (1) Except as specified under subsections (2), (3), and (4) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, must be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked (a) 145°F (63°C) or above for fifteen seconds for: (i) Raw EGGS that are broken and prepared in response to a consumer’s order and for immediate service… (4) A raw animal FOOD such as raw EGG, raw FISH, raw-marinated FISH, raw MOLLUSCAN SHELLFISH, or steak tartare; or a partially cooked FOOD such as lightly cooked FISH, soft cooked EGGS, or rare MEAT other than WHOLE MUSCLE, INTACT BEEF steaks as specified in subsection (3) of this section, may be served or offered for sale in a READY-TO-EAT form if: (a) As specified under WAC 246-215-03800 (3)(a) and (b), the FOOD ESTABLISHMENT serves a population that is not a HIGHLY SUSCEPTIBLE POPULATION.”

Eggs

In an observation on 07/08/2025 at 11:18 AM inside the refrigerator was a large 60 count box of white shelled eggs. The eggs did not have any markings on the shell that indicated the shelled eggs were pasteurized. The box showed they were great value grade AA eggs. There was no documentation on the box that showed the eggs had been pasteurized.

In an observation and interview on 07/102/205 at 1:02 PM, Staff J, Dietary Manager, stated they purchased their shelled eggs at the local store. Staff J stated the eggs the facility purchased were cage free and not pasteurized from the local grocery store. Staff J stated the facility owner preference was to purchase cage free shelled eggs. Staff J stated they often make batched scrambled eggs with the white shelled eggs for the residents. Staff J stated they go through a lot of eggs there at the facility. Staff J acknowledged to use shelled eggs they were to be pasteurized if they cooked in batches as in scrambled eggs and placed in the facility hot box to keep them warm until served to the residents. Staff J acknowledged that unpasteurized eggs have an increased risk of food borne illness as in salmonella (a type of bacteria that can make people sick as in loose stools, vomiting, and stomach cramps). At 1:07 PM, the facility received a delivery from the local grocery store that had two 60 count boxes of white shelled eggs. The shell on the eggs did not have any markings that indicated that they were pasteurized. The two boxes were labeled great value cage free eggs. There was no documentation that showed the shelled eggs had been pasteurized.

In an interview on 07/16/2025 at 3:00 PM, Collateral Contact 1, Washington State Department of Health Public Health Advisor, stated all eggs used in assisted living facilities that serves highly susceptible populations must use pasteurized shelled eggs if they batch cook as in scrambled eggs or omelets and store in a steam table or hot box to keep warm until served. The only time the facility may use a non-pasteurized shelled egg was to cook for an individual resident, and it must be served immediately.

Dietary Manual

In an interview on 07/09/2025 at 11:28 AM, Staff J stated the facility menus were signed off by the Sysco's (a large food distributor) dietician. At 11:40 AM, Staff J provided the facility dietary manual. Review of the spring/summer 2025 menu guide showed there was no documentation in the document to show who the dietician was and when the last time the dietary manual was reviewed. Staff J stated that they would check the contract of who the dietician was.

In an interview on 07/10/2025 at 12:10 PM, Staff J stated they had emailed Sysco's representative for the information on the registered dietician and when the dietary manual was last reviewed.

On 07/16/2025 at 8:40 AM, an email was sent to the facility requesting documentation to show who the dietician was and when the dietary manual was last reviewed. As of 5:30 PM, no documentation of the facility registered dietician and when the dietary manual was last reviewed was provided.

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/16/25

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

Kari Smithwick — Administrator (or Representative)

7/28/25 — Date

WAC 388-78A-2210 Medication services.

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

In an interview on 07/16/2025 at 3:00 PM, Collateral Contact 1, Washington State Department of Health Public Health Advisor, stated all eggs used in assisted living facilities that serves highly susceptible populations must use pasteurized shelled eggs if they batch cook as in scrambled eggs or omelets and store in a steam table or hot box to keep warm until served. The only time the facility may use a non-pasteurized shelled egg was to cook for an individual resident, and it must be served immediately.

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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-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 :

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents received medications as ordered for 1 of 3 residents (Resident 3 [R3]) that had prescribed parameters. This failure resulted in R3 not receiving medications as ordered and placed R3 at risk of medical complications.

Findings included…

Record review of the facility's policy and procedure, "medication services", undated, showed the policy established clear guidelines and procedures for the administration of resident's medication in the assisted living facility. The medication technician was to verify each medication against the physician's order prior to administration.

R3

Record review of R3's Service Plan Report, undated, showed R3 moved into the facility on [redacted]/2025 with multiple medical diagnoses that included [redacted], and [redacted]. The service plan showed R3 required assistance with medication administration and required registered nurse delegated services for their medication administration.

Record review of R3's Medication Administration Record (MAR), dated 06/01/2025 through 06/30/2025, showed R3's blood pressure on 06/19/2025 at 8:00 AM was 86/66, on 06/02/2025 at 8:00 AM R3's pulse was 55, and on 06/12/2025 at 8:00 AM R3's pulse was 54. R3 had an order for losartan potassium (a prescribed medication to help lower high blood pressure) and to hold if R3's systolic blood pressure (top number of the blood pressure reading) was less than 100. R3 was administered their losartan potassium on 06/19/2025. R3 had an order for carvedilol (prescribed medication to help treat high blood pressure) and to hold the medication if R3's pulse was less than 60 or systolic blood pressure was less than 100. R3 was administered their carvedilol at 8:00 AM on 06/02/2025 and 06/12/2025 with their pulse being below 60.

Record review of R3's MAR, dated 07/01/2025 through 07/08/2025, showed R3 pulse on 07/17/2025 at 8:00 PM was 55. R3's carvedilol at 8:00 PM was administered.

In an interview on 07/09/2025 at 1:42 PM, Staff M, Nursing stated all medication technicians were to administer the resident's medication per the order that was listed on the resident's medication administration record. Staff M stated if there were pulse or blood pressure parameters listed on the MAR, they were to follow those directions.

On 07/15/2025 at 10:44 AM, the facility was requested to send in any documentation for any of the concerns expressed during the preliminary exit that was on 07/10/2025 at 1:22 PM by 07/16/2025 at 5:00 PM

As of 07/16/2025 at 5:30 PM, no additional documentation was provided about the residents and their medication not being available and their physicians were notified

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, Wellspring Centralia LLC is or will be in compliance with this law and / or regulation on (Date) ~~9/15/25~~ 9/16/25

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

Kari Scotthorn
Administrator (or Representative)

7/28/25
Date

On 07/15/2025 at 10:44 AM, the facility was requested to send in any documentation for any of the concerns expressed during the preliminary exit that was on 07/10/2025 at 1:22 PM by 07/16/2025 at 5:00 PM.

As of 07/16/2025 at 5:30 PM, no additional documentation was provided about the residents and their medication not being available and their physicians were notified.

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

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

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

07/25/2025

Wellspring Centralia LLC
Wellspring Centralia LLC
1215 S Tower Ave
Centralia, WA 98531

RE: Wellspring Centralia LLC # 2685

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 07/23/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

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

You Must:

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

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

Clinton Fridley, Adult Family Home Nurse Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

eFax: (360) 992-7969
Email: rcsregion3email@dshs.wa.gov
Optional method:
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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

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

WAC 388-78A-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;

(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.

After interview and record review it was reviewed that there was incomplete documentation on residents monitoring of wellbeing in May and early June 2025. The facility identified the problem and concern, educated the staff on the policy and procedure of alert charting process. The alert monitoring of the residents change in conditions, falls, and other incidents were accurate documented after the education was completed with staff for the resident reviewed in late June 2025 and July 2025.

WAC 388-78A-2320 Intermittent nursing services systems.

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

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

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(d) Chapter 246-841 WAC, Nursing assistants; and

Based on interview and record review, the facility failed to have instruction sheets

completed for the resident specific delegated tasks. The Registered Nurse delegator completed the resident specific instruction task sheets for the residents for the delegated staff to review with step by step directions

You Are Not:

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

You May:

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

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- What specific deficiency or deficiencies you disagree with;
- Why you disagree with each deficiency; and
- Whether you want an IDR to occur in-person, by telephone or as a paper review.
- Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Enclosure

completed for the resident specific delegated tasks. The Registered Nurse delegator completed the resident specific instruction task sheets for the residents for the delegated staff to review with step by step directions

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Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E
Residential Care Services

Enclosure