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

PONDEROSA RETIREMENT CENTER INC
PONDEROSA RETIREMENT CENTER
3300 ENGLEWOOD AVE
YAKIMA, WA 98902

RE: PONDEROSA RETIREMENT CENTER License # 804

Dear Administrator:

This letter addresses Compliance Determination(s) 25574 (Completion Date 06/20/2023) and 21660 (Completion Date 05/08/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/20/2023 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-2320-2-b, WAC 388-78A-2320-1-b, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Lucinda Vautour, Licensor

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

Sincerely,

Gwin Kaercher

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PONDEROSA RETIREMENT CENTER
License/Cert.#: 804
Compliance Determination #: 21660
Investigator: Lucinda Vautour
Investigation Date(s): 03/27/2023 through 05/08/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 74822
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
A named resident did not receive the correct amount of a medication at the Assisted Living Facility (ALF).

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 7 Closed records sample size:
Observations:	Environment Cares Named Resident Residents Medications
Interviews:	Named resident Residents Facility Staff Others not associated with the facility
Record Reviews:	Resident record (assessment, care plan, chart notes, physician orders and medication administration records (MARS) Facility incident report and investigation Facility policy's

Investigation Summary:
Observations, interviews and record reviews showed that the resident's family picked up the resident and all her medications from the ALF for a home visit. Interviews and record reviews showed that the resident had not been feeling well, their blood pressure was elevated, and so the resident's family made an appointment with a physician. Interviews also showed that when family attempted to refill the resident's blood pressure medication, she found out it was almost full. The ALF acknowledged that the named resident had not been receiving the medication as ordered. The medication was to be given twice a day and had only been given once a day since admission to the ALF the residents admission, six months prior. Failed facility practice found WAC 388-78A-2120. Reference Statement of Deficiency, 05/08/2023.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PONDEROSA RETIREMENT CENTER
License/Cert.#: 804
Compliance Determination #: 21660
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 74968
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 03/27/2023 through 05/08/2023
Complainant Contact Date(s): 03/28/2023, 05/11/2023

Allegation(s):

1. A named resident did not receive the correct amount of a medication at the Assisted Living Facility (ALF).
2. A named resident was neglected by facility staff.
3. The facility falsified resident records.

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 7 Closed records sample size:
Observations:	Environment Cares Named Resident Residents Medications
Interviews:	Named resident Residents Facility Staff Others not associated with the facility
Record Reviews:	Resident record (assessment, care plan, chart notes, physician orders and medication administration records (MARS) Facility incident report and investigation Facility policy's

Investigation Summary:

1. Observations, interviews and record reviews showed that the resident's family picked up the resident and all her medications from the ALF for a home visit. Interviews and record reviews showed that the resident had not been feeling well, their blood pressure was elevated, and so the resident's family made an appointment with a physician. Interviews also showed that when family attempted to refill the resident's blood pressure medication, she found out it was almost full.
2. The ALF acknowledged that the named resident had not been receiving the medication as ordered and a medication error was made but staff did not neglect the

named resident. The medication was to be given twice a day and had only been given once a day since admission to the ALF the residents admission, six months prior.
3. The facility made a medication error and did falsify the named resident's record. Failed facility practice found WAC 388-78A-2120 (1b), (2 a). Reference Statement of Deficiency, 05/08/2023.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: PONDEROSA RETIREMENT CENTER
License/Cert.#: 804
Compliance Determination #: 21660
Investigator: Lucinda Vautour
Provider Type: Assisted Living Facility
Intake ID: 76583
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 03/27/2023 through 05/08/2023
Complainant Contact Date(s): 04/03/2023, 05/11/2023

Allegation(s):

1. A named staff member is not qualified to teach classes to staff.
2. A named staff member is not giving residents insulin as ordered.
3. Resident assessments are late and not completed by qualified staff.
4. A named facility staff member falsified a named resident record.
5. Facility staff are not delegated to give eye drops to residents.

Investigation Methods:

Sample:	Total residents: 60 Resident sample size: 7 Closed records sample size:
Observations:	Environment Cares Residents Medications
Interviews:	Named resident Residents Facility Staff Others not associated with the facility
Record Reviews:	Resident record (assessment, care plan, chart notes, physician orders and medication administration records (MARS) Facility incident report and investigation Facility policy's Employee records Nurse Delegation records

Investigation Summary:

1. Record review and interviews showed that the named staff member was qualified to teach classes they taught to facility staff.
2. Record review and interviews showed that all residents who were administered Insulin by staff received there insulin as ordered.
3. Record review showed all resident assessments reviewed were completed timely and were completed by qualified staff.

4. All resident records reviewed which included the named residents record were accurate and not falsified by staff.
5. Record review and interviews showed that on 3/27/2023 facility staff were not delegated to give eye drops to six residents that staff administered eye drops to. Record review showed that no documentation was found in the ALF's Nurse Delegation book regarding residents who require nurse delegation for eye drops. During an interview on 03/27/2023 at 12:30 PM the Registered Nurse (RN) and facility Nurse Delegator, stated that six residents could not administer their own eye drops and stated that the staff administer the drops. The facility RN also stated that they failed to complete nurse delegation for staff to administer eye drops to the residents. Failed facility practice found, WAC 388-78A-2320 (2) (b), Reference Statement of Deficiency, 05/08/2023.

Conclusion / Action:

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

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

Statement of Deficiencies	License #: 804	Compliance Determination # 21660
Plan of Correction	PONDEROSA RETIREMENT CENTER	Completion Date
Page 1 of 7	Licensee: PONDEROSA RETIREMENT CENTER INC	05/08/2023

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

The department completed data collection for an unannounced on-site complaint investigation on 03/27/2023 and 03/27/2023 of:

PONDEROSA RETIREMENT CENTER
3300 ENGLEWOOD AVE
YAKIMA, WA 98902

This document references the following complaint number(s): 74976, 74822, 74968, 76583

The following sample was selected for review during the unannounced on-site visit: 7 of 60 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Lucinda Vautour, Licensor

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

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

Gwin Kaercher
Residential Care Services

05/17/2023
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) 5-26-2023 Date

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

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

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

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

(b) Nurse delegation, if provided;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure staff were nurse delegated to provide nursing services for 6 of 6 sampled Residents (Residents 2, 3, 4, 5, 6 and 7) who received nurse delegated tasks from staff members. This failure contributed to an eye injury for one resident (Resident 2) and placed the other residents at risk of receiving services from unqualified staff.

Findings included...

Review of the Revised Code of Washington (RCW) 18.79.260, Registered Nurse - Activities Allowed - Delegation of Tasks: A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

Review of Washington Administrative Code (WAC) 246-840-930 - Criteria for delegation, before delegating a nursing task, the registered nurse delegator must determine that it is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

Resident 2.

Record review revealed that Resident 2 was admitted to the ALF on [redacted] 2021 with diagnoses which included [redacted], and [redacted]. Review of Resident 2's physician orders and April 2023 Medication Administration Record (MAR) showed, facility staff administered one drop of Ciprofloxacin Solution 3% (eye drop to treat infection) in right eye every 2

hours. Review also showed that facility staff administered one drop of Artificial tears (eye drop to treat itching and dryness) in both eyes every eight hours as needed for eye itching and dryness.

During an interview on 04/03/2023 at 11:30 AM, Collateral Contact (CC2), Resident 2's Representative, stated that on 03/31/2023 Resident 2 told her that a staff person scratched her right eye when they administered the resident's eye drops and was not wearing gloves. CC2 stated the resident's right eye was red and she stated when she left the facility, she informed Staff Member A, Administrator regarding the incident.

During an interview on 04/03/2023 at 2:40 PM, Staff A, Executive Director, confirmed that CC1 had informed him of Resident 2's eye injury that occurred on 03/31/2023 and that he told staff.

Resident 3.

Resident 3's record review revealed that the resident was admitted to the ALF on [redacted] 2018 with diagnosis which included [redacted]. Review of Resident 3's physician orders and April 2023 MAR showed, facility staff administered one drop of Artificial tears in both eyes every 12 hours as needed for eye dryness.

Resident 4.

Resident 4's record review revealed that the resident was admitted to the ALF on [redacted] 2023 with diagnosis which included [redacted]. Review of Resident 4's physician orders and April 2023 MAR showed, facility staff administered one drop of Artificial tears in both eyes every 12 hours as needed for eye dryness.

Resident 5.

Resident 5's record review revealed that the resident was admitted to the ALF on [redacted] 2020 with diagnosis which included [redacted]. Review of Resident 5's physician orders and April 2023 MAR showed, facility staff administered one drop of Latanoprost Solution 0.005% (eye drop to treat Glaucoma) in both eyes at bedtime.

Resident 6.

Resident 6's record review revealed that the resident was admitted to the ALF on [redacted] 2022 with diagnosis which included [redacted]. Review of Resident 5's physician orders and April 2023 MAR showed, facility staff administered one drop of Latanoprost

Solution 0.005% in both eyes at bedtime.

Resident 7.

Resident 7's record review revealed that the resident was admitted to the ALF on [redacted] 2018 with diagnosis which included [redacted] Review of Resident 5's physician orders and April 2023 MAR showed, facility staff administered one drop of Blink Tears 0.25% (eye drop to treat dry eyes) in both eyes four times a day.

Record review on 04/05/2023 of an email sent from Staff B dated 04/05/2023 at 8:52 AM, showed that the nurse assessed Resident 2's right eye on 04/03/2023 and 04/04/2023 and that the resident was scheduled to see their physician on 04/06/2023. The nurse's email review also showed that she was scheduled to complete nurse delegation with all staff for eye drops administration on 04/05/2023 at 2:00 PM and would send documentation to the Department.

During ALF record review of resident's receiving nurse delegation for eye drop administration, no documentation was found in the ALF's Nurse Delegation book regarding residents who require nurse delegation for eye drop administration.

During an interview on 03/27/2023 at 12:30 PM, Staff B, Registered Nurse (RN) and facility Nurse Delegator, stated that Residents 2, 3, 4, 5, 6 and 7 all could not administer their own eye drops and stated that the staff administer the drops. She also stated that she had not completed any delegation for staff to administer eye drops to Residents 2, 3, 4, 5, 6 and 7. She stated she was sorry and was aware of the delegation requirement but the only delegation paperwork she had completed was for diabetic care residents in the facility received.

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, PONDEROSA RETIREMENT CENTER is or will be in compliance with this law and / or regulation on (Date) 4-5-2023

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

Administrator (or Representative) 5-24-2023 Date

WAC 388-78A-2210 Medication services.

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

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

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

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

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement a safe medication system to ensure residents received their medications as ordered for 1 of 2 sampled residents (Resident 1) who required assistance with administration of medications. This failed practice resulted in Resident 1 not getting their medication as ordered which contributed to the resident's continued elevated blood pressures and placed the resident at risk of medical complications.

Findings included...

Record review of the facility's policy titled, "Medication Services," dated 01/2007, showed that ALF staff are to enter newly ordered medications on the resident's Medication Administration Record (MAR). Staff are to document the date the medication was ordered by the physician, the dose of the medication, the way the resident is to receive the medication, and the date and time the medication is to be administered.

During an interview on 04/03/2023 at 11:30 AM, Collateral Contact (CC1), Resident 1's Representative, stated that on 03/08/2023 they picked up Resident 1 and all their medications from the ALF for a home visit. CC1 stated that the resident had not been feeling well, and their blood pressure was elevated, so CC1 made an appointment with a physician. CC1 also stated that when she attempted to refill the resident's Atenolol (medication used to treat high blood pressure) at the pharmacy, they found out the prescription bottle almost full. CC1 called the ALF and was informed by Staff C, Licensed Practical Nurse (LPN), Director of Nursing Services (DNS) that Resident 1 had not been receiving the Atenolol medication as ordered. The medication was to be given twice a day and had only been given once a day since their admission to the ALF (six months prior). CC2 stated that when Resident 1 was given the medication as the physician ordered their blood pressure stabilized and was now feeling much better. The CC2 stated they were very unhappy and concerned with the care the resident received at the ALF.

Review of facility's Investigation Summary dated 03/17/2023, showed that on Resident's 1's admission to the ALF on [redacted]2022, Staff D, Resident Care Coordinator made an error when they transcribed the resident's medication orders on Resident 1's MAR. Staff D wrote, Atenolol 100 milligrams (mgs) 0.5 tablet daily when the physician had ordered that the

medication to be given twice a day. The summary showed Staff D no longer worked at the facility.

Review of Resident 1's MARs from Resident 1's ALF admission date of [redacted] 2022 to [redacted] 2023 showed that the resident was administered Atenolol 100 milligrams (mgs) 0.5 tablet one time daily. On [redacted] 2023 the correct dose of Atenolol 100 milligrams (mgs) 0.5 tablet two times a day was added. The review showed 173 tablets of blood pressure medication was not given as ordered since the resident's admission on [redacted] 2022.

Review of Resident 1's Weights and Vitals summary from [redacted] 2022 to [redacted] 2023 showed parameters for systolic and diastolic blood pressure (systolic measures the pressure in arteries with heart beats, diastolic measures the pressure in arteries when the heart rests, between beats). The summary showed that any readings of systolic higher than 139 and diastolic higher than 89 exceeded Resident 1's normal limit. The record showed multiple documented elevated blood pressures, almost daily since Resident 1's admission to the ALF.

Review of a 03/21/2023 physician visit showed Resident 1's blood pressure was documented as normal, and review of the resident's blood pressures since the medication error was corrected showed the pressures to be within normal limits. The resident's physician also documented that the resident stated they were feeling better since their Atenolol dose was corrected and increased to twice a day (as ordered).

During an interview on 03/27/2023 at 11:50 AM with Staff Member A, Executive Director, stated he was aware of the medication error and the staff that caused the error no longer worked at the facility.

During an interview on 03/27/2023 at 12:30 PM with Staff Member B, Registered Nurse, stated that staff did not follow the facility's medication administration policy when they did not transcribe the resident's physician orders correctly on the resident's MAR.

This is a recurring deficiency previously cited on 08/23/2022 and 03/08/2022.

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, PONDEROSA RETIREMENT CENTER is or will be in compliance with this law and / or regulation on (Date) 4-8-2023

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

Statement of Deficiencies:	License #: 804	Compliance Determination # 21660
Plan of Correction	PONDEROSA RETIREMENT CENTER	Completion Date
Page 7 of 7	Licensee: PONDEROSA RETIREMENT CENTER INC	05/08/2023

Administrator (or Representative) Date 5-24-23