STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

December 17, 2019

CHP Auburn WA Tenant Corp
Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

RE: Prestige Senior Living Auburn Meadows License #2239

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on December 16, 2019 for the deficiency or deficiencies cited in the report/s dated September 23, 2019 and found no deficiencies.

The Department staff who did the follow-up inspection:
Dahl Kim, Field Manager

If you have any questions please, contact me at (253) 234-6020.

Sincerely,

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

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Residential Care Services

Investigation Summary Report

Provider/Facility: Prestige Senior Living Auburn Meadows (818088)

Intake ID(s): 3665605

License/Cert. #: AL2239

Investigator: Leano, Cecile

Region/Unit: RCS Region 2/Unit D

Investigation Date(s): 09/04/2019 through 09/23/2019

Complainant Contact Date(s): 09/27/2019

Allegations:

Reported that alleged victim (AV) had a fall and sustained cuts and bruises. AV was at her medical provider and was told that there was an error on Enalapril (antihypertensive medication). Enalapril 20 mg supposed to be given twice a day and the facility was giving it only once a day.

Investigation Methods:

- [X] **Sample:** Three sampled resident
- [X] **Observations:** Three sampled resident's current condition. Three sampled residents' apartment. Staff to resident interaction.
- [X] **Interviews:** Three sampled resident
- [X] **Record Reviews:** Three sampled residents' assessment, negotiated service agreement, incident summary, physician's orders and medication administration record and face sheet.

Allegation Summary:

AV's antihypertensive medication has been ordered as 20 mg PO (by mouth) once a day since admission to the facility on September 2014. All of the physician's order were signed by the medical provider quarterly since 2014 showed Enalapril 20 mg one tablet PO.

Unalleged Violation(s): [X] **Yes** [ ] **No**

Lack of documentation for investigative actions due to falls and lack of reassessment due to a change in condition.

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Investigation Summary Report

Conclusion / Action:	☒ **Failed Provider Practice Identified / Citation(s) Written**	☐ **Failed Provider Practice Not Identified / No Citation Written**

See Statement of Deficiency completion date 09/23/19 for the unalleged violation.

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AGING AND LONG-TERM SUPPORT ADMINISTRATION

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Statement of Deficiencies	License #: 2239	Completion Date
Plan of Correction	Prestige Senior Living Auburn Meadows	September 23, 2019
	Licensee: CHP Auburn WA Tenant Corp	

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint number: 3665605

The department has completed data collection for the unannounced on-site complaint investigation on 9/4/2019 of:

Prestige Senior Living Auburn Meadows
945 22nd St NE
Auburn, WA 98002

The following sample was selected for review during the unannounced on-site complaint investigation : 3 of 97 current residents and 0 former residents.

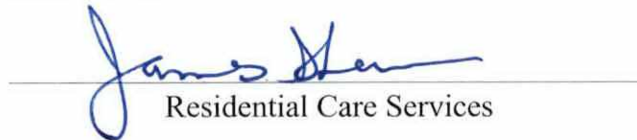
The department staff that inspected and investigated the assisted living facility:

Cecile Leano, BSN, Community Complaint Investigator

From:

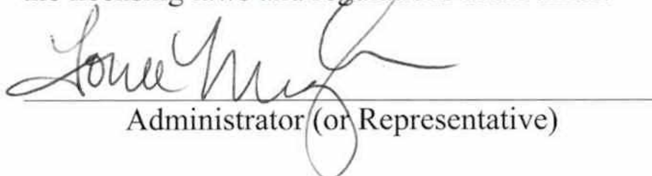
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032-2388
(253)234-6020

As a result of the on-site complaint investigation 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: 10/04/19

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.



Administrator (or Representative) — Date: 10/10/19

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WAC 388-78A-2700 Safety measures and disaster preparedness.

(2) The assisted living facility must:

(c) Investigate and document investigative actions and findings for any alleged or suspected neglect or abuse or exploitation, accident or incident jeopardizing or affecting a resident's health or life. The assisted living facility must:

(i) Determine the circumstances of the event;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to document investigative actions and findings for unwitnessed falls for three of three sampled residents (Resident #1, #2 and #3). This placed the residents at risk for abuse and harm.

Findings included...

Resident #1

Review of undated face sheet, showed Resident #1 moved in to the facility on [redacted] 2014 with multiple diagnoses including [redacted] and [redacted]

In an observation and interview on 09/04/19 at 11:07 AM, Resident #1 was in her apartment, ambulated independently with a use of four wheeled walker. The resident was observed to have a dressing on top of her left foot. The resident stated that she fell two weeks ago because of dizziness. The resident further stated that it was probably because of her blood pressure. The resident stated, "I cannot sleep at night because of the pain in my left foot. Maybe it contributed to my fall."

Review of, "Resident Incident/Accident Report" showed that Resident #1 had an unwitnessed fall on 08/22/19 at 3:15 PM. The resident fell in her bedroom. The resident sustained a skin tear on right elbow. It showed that the investigation was done 09/04/19 with documented time 10:14 AM. This was documented when the investigator asked for the investigation summary.

During an interview on 09/04/19 at 10:55 AM with Staff A, Health and Wellness Director, and Staff B, Licensed Practical Nurse (LPN), Staff B stated that there was no documentation after the fall related to investigation and no written progress notes that an investigation was completed. Staff B stated that she investigated but did not document. Staff B added that there were too many things going on and she should write a note related to the investigation she did. Staff A stated that she should write a note because she was with Staff B when they went to Resident #1 after the fall.

Resident #2

Review of undated face sheet showed Resident #2 moved in to the facility [redacted] 2017 with multiple diagnoses including [redacted] and [redacted]

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During an observation and interview on 09/04/19 at 11:15 AM, the resident was sitting on a recliner in the activity room. A wheel chair was observed next to the recliner. Staff C, Medication Technician (MedTech) and Staff D, Personal Care Attendant (PCA) assisted the resident to transfer in the wheelchair. Staff C wheeled the resident in her apartment. Resident #2 stated she did not remember when she fell but she knew she fell.

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Review of the "Incident/Accident Report", showed Resident #2 had unwitnessed fall on 08/28/19 at 9:45 AM and 08/30/19 at 10:36 AM. Both falls had happened in the resident's bedroom and had no injury.

Resident #3
Review of undated face sheet, showed Resident #3 moved in to the facility on [redacted] 2019 with multiple diagnoses including [redacted] and [redacted].

During an observation and interview on 09/04/19 at 1:50 pm, Resident #3 was in the activity room. Resident #3 ambulated without an assistive device independently and went to the private dining room. The resident stated she fell in the middle of the night when she lost her balance. The resident added that she hit her right knee and she was in pain.

Review of the "Incident/Accident Report", showed Resident #3 had an unwitnessed fall on 09/02/19 at 9:00 AM. The resident found in the kitchen floor. No injury was noted.

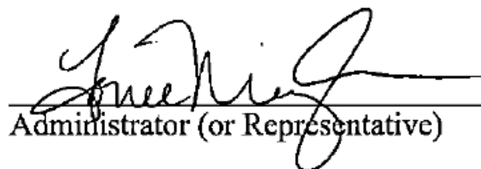
Review of the facility's policies and procedure for Abuse and Neglect showed, "Investigation of suspected abuse will be documented on an internal incident report and must include findings and result/outcome of the investigation."

During an interview on 09/04/19 at 11:33 AM, Staff B, was asked for the investigation summary of Resident #2 and #3's incident. Staff B stated that the Incident/Accident Report was a preliminary incident report completed by the staff that was working when the incident took place. Staff B stated that the "Resident Incident/Accident Report" was the incident summary that she should complete and was not completed because the facility was behind. Staff B stated, she cannot show what was not documented.

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, Prestige Senior Living Auburn Meadows is or will be in compliance with this law and / or regulation on (Date) 11/7/19 . In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

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



Administrator (or Representative) 10/10/19 Date

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WAC 388-78A-2100 On-going assessments. The assisted living facility must:

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

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

(b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to reassess one of three residents (Resident #2) who had a change in condition and had multiple falls, and the negotiated service agreement (NSA) no longer met her care needs. This placed the resident at risk of harm.

Findings included...

Review of undated face sheet showed Resident #2 moved in to the facility [redacted] 2017 with multiple diagnoses including [redacted] and [redacted]

During an observation and interview on 09/04/19 at 11:15 AM, the resident was sitting on a recliner in the activity room. A wheel chair was observed next to the recliner. Staff C, Medication Technician (MedTech) and Staff D, Personal Care Attendant (PCA) assisted the resident to transfer in the wheelchair. Staff C wheeled the resident in her apartment.

In an interview on 09/04/19 at 1:28 PM, Staff C stated that Resident #2 needed two person to assist her with transfers and needed total care with toilet use.

Review of Service Plan Agreement, equivalent to negotiated service agreement (NSA) with effective date 03/04/19 showed, Resident #2 was able to manage ambulation, independent with mobility, able to manage transfers and able to manage toileting independently.

Review of incident records of Resident #2 showed the following; 1) Injury fall on 07/15/19 at 1:55 AM. The resident was found in the bathroom floor and sustained a bump on the right forehead and bottom left lip was bleeding. The resident stated that she fell while she was trying to go to the bathroom. 2) Non-injury fall on 07/24/19 at 3:50 AM. The resident stated that she was trying to hurry to the bathroom and slid off the edge of her bed. 3) Non-injury fall on 08/08/19 at 12:40 PM. The resident stated that she was trying to use the bathroom and fell on the floor. 4) Non-injury fall on 08/28/19 at 9:45 AM. The resident stated that she needed to go to the bathroom and she fell. 5) Non-injury fall on 08/30/19 at 10:36 AM. The resident stated that she slipped off the bed and sat on the floor.

Review of "Resident Health Evaluation/Assessment", completed on 02/21/19, showed Resident #2 was independent with transfers, ambulation, dressing, hygiene and bathing.

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In an interview on 09/04/19 at 2:35 PM, Staff A, Health and Wellness Director, Staff B, Licensed Practical Nurse (LPN) and Staff E, Director were present, Staff A stated that she did the current assessment of Resident #2 on 09/04/19 when the department was already at the facility and Resident #2 was in her to do list. Staff A stated that she was not able to thoroughly complete the assessment and did not update the NSA. Staff A added that that she was aware that she needed to reassess Resident #2 for a change in her condition. Staff E stated that Resident #2

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had an on and off change in condition and it happened couple of weeks ago.

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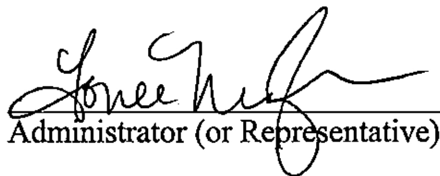

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