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

SCRIBER GARDENS LLC

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

RE: SCRIBER GARDENS LLC License # 2203

Dear Administrator:

This letter addresses Compliance Determination(s) 27271 (Completion Date 07/27/2023) and 22719 (Completion Date 05/15/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/27/2023 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-2250-1, WAC 388-78A-2250-4, WAC 388-78A-2250-3

The Department staff who did the on-site verification:
Christine Banta, Community Complaint investigator

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

Sincerely,

Kim Ripley

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

Residential Care Services
Investigation Summary Report

Provider/Facility: SCRIBER GARDENS LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2203
Compliance Determination #: 22719 **Intake ID:** 77341
Investigator: Wesler Dumecquias **Region/Unit #:** RCS Region 2 / Unit A
Investigation Date(s): 04/19/2023 through 05/15/2023
Complainant Contact Date(s): 04/12/2023, 05/12/2023, 05/17/2023

Allegation(s):

1. The Named Resident (NR) was given five wrong medications that may have caused serious side effects.
2. There was lack of resident identifier and medications were given crushed and mixed with apple sauce.
3. NR was found on the floor in another resident's room.
4. There was no adequate staffing.
5. The resident rooms were locked.
6. The NR's blood pressure was only to be measured when staff had time. The NR's well being was not taken care of in relation to the medication error.
7. The facility had no Executive Director to address the concerns.

Investigation Methods:

Sample:	Total residents: 46 Resident sample size: 5 Closed records sample size: 2
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified resident Identified staff Nursing staff Regional Nurse Executive Director Residents Family members
Record Reviews:	Incident investigation Facility policies Personnel files Staff training records Medication administration records

Care plan
Physician orders
facility alert and monitoring sheets.
MD notification
Charting notes
Staff Schedules
In service for medication services.

Investigation Summary:

It was determined:
1. The Assisted Living facility (ALF) conducted an investigation and found the staff committed a medication error. Findings indicated that the staff was distracted and was talking to another resident while giving medications. As a result, staff accidentally gave the medication to the NR who switched seat to another resident. The facility followed Assisted Living Guide Book in completing their investigation. Staff had 1:1 retraining on medication assistance and administration. The facility reviewed the staff's training and certification. The facility placed the NR on alert, monitoring and contacted the primary care physician (PCP) for advise. The facility notified the NR's family. There was no resident outcome identified as a result. No failed practice identified.
2. The facility has a system in place for residents' identification prior to giving medications. The MedTechs (MT) or Licensed nurses (LN) uses resident's photos, compares room numbers in the computers and they asked residents their names. The MT's and LN's were giving the NR and sampled resident (SR) medications in an altered or crushed form without physicians' orders. Failed Practice identified. WAC 388-78A-2250 (1)(4);
Alteration of medications.
3. The NR wanders around the hallway and at times enters residents' rooms. The facility placed the resident on monitoring for the wandering behavior and the care plan was updated. The facility investigated the alleged fall and ruled out abuse and neglect. The NR was found in another residents' room sitting on the floor. The NR had no recollection of the incident. The resident was placed on alert charting and monitoring. No failed practice identified.
4. The facility has 2 caregivers and a MedTech for day and evening and a caregiver and a MedTech for the night shift on their Memory care unit. Observation during unannounced visit showed that staff were able to provide the care to the residents. The facility has a system in place during staff breaks to maintain staff presence. Interview of sampled residents indicated satisfaction with their care and services.
5. Observation showed that NR was able to access his room and was not locked. Other resident who are able are provided keys for them to lock and open their rooms. Observation and Interview with sampled resident showed that they are able to get in and out of their rooms. Staff interview indicated that rooms of residents are not being locked. No failed practice identified.
6. The NR was placed on alert charting and monitoring as documented in their computer system narrative charting. The facility has a communication log regarding issues, concerns and incident reports. Record review showed the primary care physician instructed the facility to monitor for sedation and adverse effects. Records review and Staff interview showed and indicated that the NRs' vital signs, sedation status, activities and possible adverse reactions were monitored. No resident outcome. No failed practice identified.
7. The facility hired a new Executive Director who officially started on 04/10/2023. The facility had regional administrators as designees to contact for concerns in the absence of the Executive Director.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2203	Compliance Determination # 22719
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 1 of 4	Licensee: SCRIBER GARDENS LLC	05/15/2023

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 04/19/2023 and 04/19/2023 of:

SCRIBER GARDENS LLC
6024 200TH ST SW
LYNNWOOD, WA 98036

This document references the following complaint number(s): 77341, 77391, 77084

The following sample was selected for review during the unannounced on-site visit: 5 of 46 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Wesler Dumecquias, Community Complaint Investigator

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

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

Kim Ripley
Residential Care Services

05/15/2023
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.

Betsy Franke
Administrator (or Representative)

5/03/23
Date

WAC 388-78A-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review the Assisted Living Facility (ALF) failed to obtain physicians' orders to crush medications for 2 of 5 sampled residents (Resident 1 and 2), identified as receiving medication assistance. This placed Residents 1 and 2 at risk for medication malabsorption and unwanted adverse as well as side effects from receiving medications crushed without an order.

Findings included...

Facility Policy titled; "MEDICATION SERVICES Policy & Procedure Number: N1 Policy " dated 07/14/2022, showed before altering any medication, staff will receive and document permission from the pharmacy or prescribing doctor.

Review of an undated ALF document titled; "MEDICATION SERVICES, IN-SERVICE" showed with a physician's order, some medications may be crushed (altered) to make taking them easier for the Resident. The order should be documented in the "Info Orders" section of the EMAR.

Resident 1
Review of a face sheet showed that Resident 1 was admitted on [redacted]/2022 with multiple diagnoses including [redacted].

Review of resident care plan dated 06/21/2022 showed Resident 1 was on medication assistance. It showed medication will be prepared as directed by the physician. The care plan showed an additional instruction that stated; "CG [caregivers] to crush medications

and place in applesauce or pudding".

Review of Physician's order dated 04/21/2023 showed that Resident 1 takes 7 oral medications in tablet and capsule form every day.

Review of Medication Administration Record's (MAR) dated 04/24/2023 showed Resident 1 had no notations of crush orders.

In an interview on 04/2/2023 at 12:21 PM, STAFF G, Memory Care Director (MCD), stated that Resident 1 took all their medications crushed with applesauce.

In an interview on 04/26/2023 at 12:40 PM, Staff F, Med Tech, stated that they give Resident 1's medications crushed in applesauce or pudding.

In an email on 4/27/2023 at 3:03 PM, Staff A, Executive Director, stated that they do not have orders to crush medications for Resident 1 and they have contacted Primary Care Physician (PCP) to obtain an order.

Resident 2
Review of a face sheet showed that Resident 2 was admitted on [redacted]/2021 with multiple diagnoses including [redacted].

Review of resident care plan dated 11/07/2022 showed Resident 2 was on medication assistance. The care plan showed staff will assist, record, maintain, and reorder all Resident 2's medications.

Review of Medication Administration Record dated 04/24/2023 showed Resident 2 took 13 oral medications in tablet and capsule form and there were no notations of crush orders.

In an interview on 04/2/2023 at 12:21 PM, Staff G stated that Resident 2 took their medications crushed with applesauce.

In an interview on 04/26/2023 at 12:40 PM, Staff F stated that they give Resident 2's medication crushed in applesauce or pudding.

In an email on 4/27/2023 at 3:03 PM, Staff A stated that they do not have orders to crush medications for Resident 2 and they have contacted Primary Care Physician (PCP) to obtain an order.

Statement of Deficiencies	License #: 2203	Compliance Determination # 22719
Plan of Correction	SCRIBER GARDENS LLC	Completion Date
Page 4 of 4	Licensee: SCRIBER GARDENS LLC	05/15/2023

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, SCRIBER GARDENS LLC is or will be in compliance with this law and / or regulation on (Date) 7/3/2023 .

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

Betsy Frankie — Administrator (or Representative)

5/23/23 — Date