STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Pacifica Kenmore LLC
Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

RE: Kenmore Senior Living License # 2566

Dear Administrator:

This letter addresses Compliance Determination(s) 40876 (Completion Date 05/30/2024) and 36327 (Completion Date 03/08/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/30/2024 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-2240, WAC 388-78A-2600-2-r

The Department staff who did the off-site verification:
Hayley Pinkham, ALF Licensor

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2566
Compliance Determination #: 36327
Intake ID: 115722
Investigator: Hayley Pinkham
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 02/05/2024 through 03/08/2024
Complainant Contact Date(s): 03/08/2024

Allegation(s):

1) The Named Resident (NR) went without her full dose of medication for a week.
2) The Assisted Living Facility (ALF) administrative staff have not responded to requests for an explanation for the NR missing her full medication dose.

Investigation Methods:

Sample:	Total residents: 76 Resident sample size: 2 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Facility policies Medical records

Investigation Summary:

1) Interview showed the NR could not recall missing medications. Interview with sampled residents showed no reported concerns with care and/or services. Interview and record review showed the NR did miss medication for seven days due to the ALF not responding to refill needs/requests from pharmacy. Deficient practice identified.
2) Interview and record review showed the ALF administrative staff did not implement the grievance policy by responding in a timely manner to requests for information regarding the missed medications. Deficient practice identified.

Conclusion / Action:

☒ 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 #: 2566	Compliance Determination # 36327
Plan of Correction	Kenmore Senior Living	Completion Date
Page 1 of 5	Licensee: Pacifica Kenmore LLC	03/08/2024

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 02/05/2024 and 02/05/2024 of:

Kenmore Senior Living
7221 NE 182nd St
Kenmore, WA 98028

This document references the following complaint number(s): 115722, 115876

The following sample was selected for review during the unannounced on-site visit: 2 of 76 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Jamie Singer — Residential Care Services

3/11/2024 — 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.

Statement of Deficiencies	License # 2566	Compliance Determination # 36327
Plan of Correction	Kenmore Senior Living	Completion Date
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Administrator (or Representative) 3/20/2024 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 Assisted Living Facility (ALF) failed to ensure 1 of 2 residents (Resident 1) received their medications as prescribed by a physician. The failure caused Resident 1 to go without a medication that could cause withdrawal symptoms.

Findings included. .

Note: Review of the WebMD website showed venlafaxine is a medication used to treat depression. Venlafaxine belongs to a class of drugs known as serotonin-norepinephrine reuptake inhibitors (SNRIs). Venlafaxine works by helping to restore the balance of certain natural substances (serotonin and norepinephrine) in the brain. Some conditions may become worse when this drug is suddenly stopped, such as confusion, mood swings, blurred vision, headache, tiredness, and sleep changes. Dosage may need to be gradually decreased to reduce side effects.

Record review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2022 with multiple medically disabling diagnoses including [redacted]. Review of an Assessment, dated 02/08/2023, showed Resident 1 required the ALF to manage medications and report to the physician any missed doses.

Record review of a January 2024 Medication Administration Record (MAR) showed Resident 1 had physician's orders for venlafaxine, a 37.5 milligram (mg) tablet and a 75 mg tablet to equal a 112.5mg dose daily. Record showed Resident 1 did not receive the venlafaxine 37.5 mg from 01/02/2024 through 01/08/2024.

In an interview, on 02/05/2024 at 2:02 PM, Staff A (Resident Care Director) stated Resident 1's supply of the 37.5 milligram tablets of venlafaxine had run out.

Record review showed no communication to the pharmacy or the physician regarding a refill of the 37.5 milligram tablets of venlafaxine prior to Resident 1 running out. Records showed a Progress Note, dated 01/07/2024, that showed Staff B (Medication Technician) documenting she called the pharmacy to request a refill the 37.5 milligram tablets of

Administrator (or Representative) Date

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In an interview, on 02/05/2024 at 2:02 PM, Staff A (Resident Care Director) stated Resident 1's supply of the 37.5 milligram tablets of venlafaxine had run out.

Record review showed no communication to the pharmacy or the physician regarding a refill of the 37.5 milligram tablets of venlafaxine prior to Resident 1 running out. Records showed a Progress Note, dated 01/07/2024, that showed Staff B (Medication Technician) documenting she called the pharmacy to request a refill the 37.5 milligram tablets of

venlafaxine. The first documented refill request made by the ALF was seven days after Resident 1 ran out of the medication.

In an interview, on 02/08/2024 at 2:58 PM, Collateral Contact 1 (CC1- Pharmacy Manager) stated the pharmacy sent a prescription renewal report to Staff A on 11/11/2023, 11/21/2023, 11/28/2023, and on 12/05/2023 requesting the ALF to coordinate with the prescribing physician.

Record review showed no communication from the ALF, with the prescribing physician in response to the prescription renewal reports sent from the pharmacy on 11/11/2023, 11/21/2023, 11/28/2023 and on 12/05/2023.

In an interview, on 02/22/2024 at 2:42 PM, Collateral Contact 2 (CC2-Legal Representative) stated she observed when the full dose of venlafaxine was missed for seven days Resident 1 presented with increased confusion and anxiety, was asking more concerning questions, was sleepier, "going into a dream like state."

In an interview, on 02/23/2023 at 10:41 PM, Staff A stated the Medication Technicians should have contacted the pharmacy when Resident 1's 37.5 milligram tablets of venlafaxine were running low. Staff A stated she did not see the prescription renewal reports from the pharmacy sent on 11/11/2023, 11/21/2023, 11/28/2023 but saw the one from 12/05/2023. Staff A could not provide any documentation showing the ALF responded to the report from 12/05/2023. At 11:10 AM Staff A confirmed that stopping a medication such as venlafaxine suddenly is not safe.

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, Kenmore Senior Living is or will be in compliance with this law and / or regulation on (Date) 4/12/2024

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

Administrator (or Representative) 3/20/2024 Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do.

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060; and

venlafaxine. The first documented refill request made by the ALF was seven days after Resident 1 ran out of the medication.

In an interview, on 02/08/2024 at 2:58 PM, Collateral Contact 1 (CC1- Pharmacy Manager) stated the pharmacy sent a prescription renewal report to Staff A on 11/11/2023, 11/21/2023, 11/28/2023, and on 12/05/2023 requesting the ALF to coordinate with the prescribing physician.

Record review showed no communication from the ALF, with the prescribing physician in response to the prescription renewal reports sent from the pharmacy on 11/11/2023, 11/21/2023, 11/28/2023, and on 12/05/2023.

In an interview, on 02/22/2024 at 2:42 PM, Collateral Contact 2 (CC2-Legal Representative) stated she observed when the full dose of venlafaxine was missed for seven days Resident 1 presented with increased confusion and anxiety, was asking more concerning questions, was sleepier, "going into a dream like state."

In an interview, on 02/23/2023 at 10:41 PM, Staff A stated the Medication Technicians should have contacted the pharmacy when Resident 1's 37.5 milligram tablets of venlafaxine were running low. Staff A stated she did not see the prescription renewal reports from the pharmacy sent on 11/11/2023, 11/21/2023, 11/28/2023 but saw the one from 12/05/2023. Staff A could not provide any documentation showing the ALF responded to the report from 12/05/2023. At 11:10 AM Staff A confirmed that stopping a medication such as venlafaxine suddenly is not safe.

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Administrator (or Representative) Date

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(r) When receiving and responding to resident grievances consistent with RCW 70.129.060 ; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement their grievance policy and respond to 1 of 2 sampled residents (Resident 1) representative's concerns. This placed Resident 1 at risk of further medications system issues when the ALF did not respond the representative in a timely manner.

Findings included...

Record review of the ALF's undated policy titled, "Resident Grievances" showed the ALF shall have in place a structured complaint and grievance policy to address issues promptly and show commitment to quality care and resident satisfaction. The ALF will document all concerns, complaints, and grievance by staff on the resident complaint and grievance process log. The ALF will initiate the investigation within 5 days of receiving and complete within 30 days. The ALF will communicate the results of the investigation and action taken to resolve the situation to the complainant preferably through a meeting in person or send a follow up letter.

Record review of a Face Sheet showed the ALF admitted Resident 1 on [redacted]/2022.

Record review showed Collateral Contact 2 (CC2 – Resident 1's Legal Representative) sent a grievance via email on 01/12/2024 to Staff A (Resident Care Director) detailing concerns regarding Resident 1 not receiving medication. The email detailed questions specific to the missed medications, comments regarding the outcome of missed medications, and requesting the ALF's response and plan to correct the issue.

In interview, on 02/22/2024 at 2:42 PM, the CC2 stated Staff A did not respond to the email she sent on 01/12/2024. CC2 stated she followed up with another email on 01/19/2024.

Record review showed Staff A responded via email to CC2's emails of 01/12/2024 and 01/19/2024, on 01/26/2024, fourteen days after the initial grievance.

In interview, on 02/23/2024 at 11:10 AM, Staff A stated she did not see CC2's emails and confirmed she did not respond until 01/26/2024.

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) — 3/20/2024 Date

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

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