STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

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 and complaint investigation on 08/25/2026, 08/26/2026, 08/27/2026, 08/28/2026 and 09/01/2026 of:

Cherrywood Care
100 E Dalke Ave
Spokane, WA 99208

This document references the following complaint numbers: 236103.

The following sample was selected for review during the unannounced on-site visit: 10 of 51 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Tethra Wales, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor
Veronica Jackson, Assisted Living Facility Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

This document was prepared by Residential Care Services for the Locator website.

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-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

This requirement was not met as evidenced by:

Based upon interview and record review, the facility failed to ensure that medical providers were contacted in a timely manner for 2 of 7 sampled residents (Resident 5 and 7) who experienced a change in health condition. This failure prevented the residents' providers from responding to the residents' changing medical conditions and placed the residents at risk of serious health complications.

Findings included…

Review of the facility's titled "Medication Administration Policy", dated 12/2024, showed that the facility was to notify the provider of changes in condition related to their medication regimen, including improvement or decline. Further review showed that the communication with the provider would be documented.

<Resident 7>

Review of Resident 7's undated Face Sheet showed a diagnosis of [redacted]

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Review of Resident 7's Service Evaluation/Negotiated Service Plan (the facility's combined assessment and negotiated service agreement), dated 07/21/2026, showed that Resident 7 required assistance coordinating their care with their physician.

Review of Resident 7's PCP order, dated 07/28/2026, showed that the facility was to notify the PCP if the resident's blood sugar was greater than 450.

In an interview on 08/27/2026 at 4:00 PM, Staff H, Medication Technician, stated that Resident 7's blood sugar was so high that morning that it wouldn't register on the glucose monitor. When asked how high it would need to be to not register, Staff H stated over 500. Staff H further stated that they also attempted to take Resident 7's blood sugar on the facility's glucometer and it did not register. When asked if they had notified the resident's primary care provider (PCP), Staff H stated that they had not. Staff H further stated that supervisors notified the residents' PCPs of high blood sugars if there was an order to, but Resident 7 did not have an order to notify the PCP.

Review of Resident 7's August 2026 Medication Administration Record (MAR) showed an order for fast acting insulin to be given four times daily for blood sugar over 150. Further review showed no instructions to notify the PCP if blood sugar was 451 or over. Further review showed that blood sugar was 451 or higher on the following days:

08/04/2026 4:00 PM=489
08/06/2026 12:00 PM-593
08/07/2026 12:00 PM=452
08/08/2026 8:00 PM=500
08/11/2026 8:00 AM=482
08/15/2026 12:00 PM=452
08/16/2026 12:00 PM=500
08/20/2026 12:00 PM=500
08/22/2026 8:00 AM=452
08/22/2026 12:00 PM=452
08/24/2026 8:00 AM=500
08/25/2026 8:00 PM=470
08/26/2026 12:00 PM=482
08/27/2026 8:00 AM= too high to register per progress notes
08/28/2026 8:00 AM=572

Review of Resident 7's progress note, dated 08/27/2026, entered by Staff H, showed that they checked the resident's blood sugar on the glucose monitor and the monitor read high. Staff H then checked Resident 7's blood sugar using a finger prick and the glucose monitor still read high, with no visible numbers. The progress note further showed that the supervisor was notified.

In an interview on 08/28/2026 at 9:36 AM, Staff A, Executive Director, and Staff F, Registered Nurse Delegator, stated that the facility did not notify residents' PCPs of high blood sugars unless there was an order to do so. Staff A stated that Resident 7 did not

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have an order to notify their PCP. When asked if the PCP had been notified of Resident 7's high blood sugar taken that morning, Staff A stated they were unaware it was high.

In an interview on 08/28/2026 at 2:10 PM, CC1, Clinical Support Assistant for Resident 7's PCP, stated that they had not been notified by the facility of Resident 7's high blood sugars until 08/27/2026, after the department had initiated the inspection.

Review of an email, dated 08/27/2026, sent by Staff G, Resident Care Coordinator, to CC1, showed it read "[Resident 7] had a very BS today" and did not include the blood sugar reading.

<Resident 5>

Review of Resident 5's undated Face Sheet showed that the resident had a diagnosis of [redacted]

Review of Resident 5's PCP order, dated 12/17/2024, confirmed that BP checks were ordered twice a week, and to notify the PCP if less than 90/50 or greater than 160/100.

Review of Resident 5's Service Evaluation/Negotiated Service Plan, dated 11/17/2025, showed that Resident 5 required assistance with monitoring of their blood pressure (BP) and coordination of care with their physician.

Review of Resident 5's May, June, July, and August 2026 MARs, showed an order for blood pressure checks twice a week, with instructions to notify their PCP if less than 90/50 or greater than 160/100. Further review showed Resident 5's BP was higher than 160/100 on the following dates:

05/26/2026 170/111
06/02/2026 175/99
08/04/2026 184/84
08/25/2026 172/93

In an interview on 08/25/2026, Staff A stated that Staff G, Resident Care Coordinator, contacted the provider by email when blood pressures were outside parameters. Staff A stated they would request copies of the email communications related to Resident 5's high blood pressure readings.

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Review of two emails, dated 08/26/2026 and 08/27/2026, showed that the email communications by the facility were sent to Resident 5's PCP after the department had inquired about notifications to the provider. Further review showed that the email dated 08/26/2026 inquired about the PCP's preferred method of communication and that the email dated 08/27/2026 notified the PCP of Resident 5's high blood pressure reading on 08/25/2026.

In an interview on 08/28/2026 at 10:18 AM, Staff A stated that the facility did not have any documentation prior to the inspection related to communications with the provider about Resident 5's high blood pressure readings. Staff A further stated that they had reached out to Resident 5's PCP and requested copies of any documentation the PCP could provide.

In an interview on 08/28/2026 at 2:10 PM, CC1 stated that the PCP had not been notified by the facility of Resident 5's high blood pressures until 08/27/2026, after the department had initiated the inspection.

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, Cherrywood Care 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:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(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 ;

(ii) 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:

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Based on observation, interview and record review, the facility failed to complete an assessment for 2 of 2 residents, (Resident 2 and 8) and update an assessment when there was a change of condition for 3 of 5 residents (Resident 1, 5 and 7). This failure resulted in the residents not being assessed for self-administration of medications, devices and services, and diabetes history, signs, and symptoms. This placed residents at risk for unmet care needs, medication errors, and health complications.

Findings included…

<Incomplete assessments>

-Resident 2

Review of Resident 2's undated Face Sheet showed they were admitted to the facility on [redacted]/2020.

Review of Resident 2's annual Service Evaluation/Negotiated Service Plans (the facility's combined assessment and negotiated service agreement), dated 08/06/2026, showed Resident 2's assessment was blank and that the resident had not received a full assessment due to "the resident has refused to complete annual assessment." Further review showed that the Service Evaluation/Negotiated Service Plan was signed by Staff F, Registered Nurse Delegator.

-Resident 8

Review of Resident 8's undated Face Sheet showed they were admitted to the facility on [redacted]/2021.

Review of Resident 8's annual Service Evaluation/Negotiated Service Plan, dated 08/11/2026, showed Resident 8's assessment was blank and the resident had not received a full assessment due to "the resident has refused to complete annual assessment." Further review showed that the Service Evaluation/Negotiated Service Plan was signed by Staff F.

In an interview on 08/26/2026 at 3:36 PM, Staff F stated that they had not completed the assessments for Resident 2 and 8, "because they won't talk to me." Staff F further stated that they did not feel they could assess the residents because the residents would not interview and would not let them in their rooms. Staff F was not aware that the assessments needed to be consistent with the Department of Social and Health Services' current annual assessment or that they could draw information from personal observation and care staff.

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<Assessments not updated >

- Resident 7

Review of Resident 7's undated Face Sheet showed that Resident 7 admitted to the facility on [redacted]/2026. Further review showed that Resident 7 had a diagnosis of [redacted]

Review of Resident 7's Pre-Admission Assessment, dated 06/29/2026, showed the resident had a diagnosis of [redacted] at the time of admission, and that the resident had a hospital admission for high blood sugar within the six months prior to the pre-admission assessment.

Review of Resident 7's Service Evaluation/Negotiated Service Plan, dated 07/21/2026, showed that the only references to Resident 7's [redacted] diagnosis appeared in the dietary section where it was noted that the resident preferred a diabetic-friendly diet, and the mobility section of the service plan where it was noted that Resident 7 had a fall seven months prior to admission that was evaluated at the hospital and determined to be a result of low blood sugar due to their diabetes. Further review showed that the medication assessment portion did not reference their diabetes, did not include Resident 7's history of low and high blood sugars, how the resident's high and low blood sugars present (signs and symptoms), or Resident 7's use of a blood glucose monitor.

Review of Resident 7's July 2026 Medication Administration Record (MAR) showed a blood sugar reading of 500 on 07/30/2026.

Review of Resident 7's August 2026 Medication Administration Record (MAR) showed 15 times when Resident 7's blood sugar read over 450, and included a reading of 593 on 08/06/2026 and a reading of 572 on 08/28/2026.

In an interview on 08/28/2026 at 12:15 PM, Staff F, stated that they were not aware that diabetic care was required in the assessment.

- Resident 1

Review of Resident 1's undated Face Sheet showed that the resident's admission date was [redacted]/2025.

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Review of Resident 1's Service Evaluation/Negotiated Service Plan (the facility's combined assessment and negotiated service agreement), 10/30/2025, showed that the resident received medication assistance from staff, was unable to self-administer medications, and that all breathing devices and eye drops were to be administered by staff.

Observation on 08/26/2026 at 10:38 AM, showed a nebulizer, cough drops, eye drops and acetaminophen (pain reliever) in Resident 1's room. In an interview at that same time, Resident 1 stated that they self-administer those treatments and medications.

Review of Resident 1's September 2026 Medication Administration Record showed that the resident self-administered the nebulizer, cough drops, eye drops and acetaminophen.

In an interview on 08/27/2026 at 2:20 PM, Staff F, Registered Nurse Delegator stated that they had not completed a self-medication assessment. At that same time, Staff A, Executive Director, confirmed that they did not have a self-medication assessment for Resident 1.

- Resident 5

Review of Resident 5's undated Face Sheet showed a diagnoses of [redacted] and [redacted]

Review of Resident 5's Service Evaluation/Negotiated Service Plan, dated 11/17/2025, showed that Resident 5 wore glasses and had adequate vision.

Review of Resident 5's Developmental Disabilities Administration assessment, dated 06/18/2026, showed Resident 5 wore contacts for vision difficulties, and noted that Resident 5's vision had deteriorated, and that they would be having surgery on both eyes. Further review showed Resident 5 is "almost blind in his left eye" and may require assistance navigating due to the loss of vision. Review showed that Resident 5 had severe sleep apnea and used a Continuous Positive Airway Pressure (CPAP) machine daily.

As of 08/28/2026 there were no assessment updates to the NSA Resident 5's contacts, their history of macular degeneration, limited vision without their contacts, or need for surgery. Review showed no documentation of Resident 5's use of a CPAP machine or instructions outlining the party responsible for cleaning, maintaining and reordering required supplies and who would step in if Resident 5 was unable to do so.

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In an interview on 08/25/2026 at 4:12 PM, Staff A stated that Resident 5 wore glasses and had not yet had their eye surgery. Staff A further stated that they had not seen a CPAP for Resident 5 since they moved into the facility.

In an interview on 08/27/2026 at 1:12 PM, Resident 5 confirmed that they had vision challenges and were going to have eye surgery soon. Resident 5 stated that they wore contacts that helped them to see well enough to navigate. Observation at the time of the interview showed that Resident 5 was not wearing glasses.

In an interview on 08/28/2026 at 2:32 PM, Resident 5 stated that they used a CPAP machine every night. Resident 5 stated that they cleaned the CPAP and that the supplies were delivered to them, but they did not know who ordered them. Observation conducted during the interview showed a CPAP machine on Resident 5's bed pillow.

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, Cherrywood Care 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-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to outline known behavioral interventions in the resident's negotiated service agreement for 1 of 9 residents (Resident 9). This failure placed residents and staff at risk of harm and required Resident 9 to navigate behavioral challenges without identified supports from staff.

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Findings included…

Review of Resident 9's Behavior Support Plan, dated 04/27/2026, showed it was completed by an outside behavioral health provider and listed a diagnosis of [redacted]. Further review showed preventative measures that included daily check-ins by staff to ease anxiety and cueing of coping strategies. Review showed interventions in the event of an escalation that included asking the resident to remain in a private area while revisiting them at 10-15 minute intervals or contacting the behavioral support specialist, crisis line, or 911.

Review of Resident 9's Service Evaluation/Negotiated Service Plan (the facility's combined assessment and negotiated service agreement), dated 06/04/2026, showed that Resident 9 had anxiety or agitation that required staff management and that they had episodes of yelling out at staff and being verbally aggressive. Further review showed the outbursts got worse and more frequent when Resident 9 drank alcohol. Review showed that staff were to de-escalate and redirect the resident when these episodes occurred by encouraging Resident 9 to take a break. Further review showed no instruction to contact the behavior support specialist or 911 when Resident 9 became escalated, none of the proactive interventions to prevent escalations included in the behavior support plan, or actions or interventions that address Resident 9's alcohol use or inappropriate actions towards other residents.

Review of an Incident Report, dated 08/12/2026, showed that 911 was called after Resident 9 swung at Staff A, hit them in the arm, and began shoving their body against Staff A. Further review showed that the incident was witnessed by several residents and responded to by police.

During the confidential resident group meeting with the department on 08/26/2026 at 10:30 AM, multiple residents raised concerns about Resident 9 and stated that they were afraid of Resident 9, particularly when the resident had been drinking. Residents shared about the altercation between Resident 9 and Staff A that was witnessed by multiple residents in the lobby and informed the survey team that Resident 9 was in court that morning for assault. Residents identified the dining room during meals as a common location for Resident 9's escalations, leaving them unable to avoid Resident 9's behaviors.

In an interview on 08/26/2026 at 2:43 PM, Staff A, Executive Director, stated that Resident 9 backhanded them on 08/12/2026 in the front lobby after they became upset about a conversation Staff A was having with an acquaintance of Resident 9. Staff A stated that Resident 9 had been drinking, "got in my face" and was bumping them. Staff A stated that they instructed a staff member to call 911 because they were unable to de-escalate Resident 9 when they "get like that." Staff A stated that the police responded and ticketed Resident 9. Staff A further stated that Resident 9 had court the day of the interview for a charge of 4th degree assault related to the incident. Staff A stated that Resident 9 is on a behavioral support plan through an outside provider.

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Review of Resident 9's July and August 2026 Progress Notes showed the following:

06/21/2026 Resident had a verbal outburst this morning regarding events from last week.

07/14/2026 Resident is heavily intoxicated and yelling, drinking and smoking in their room.

08/11/2026 Resident was restricting another resident from eating their food during lunch. The other resident was picking at their plate and Resident 9 grabbed their arm and told them to either stop picking at it or get up and leave. Resident 9 then told the other resident that they were done eating and that they needed to go upstairs right now.

08/13/2026 Resident is telling other residents at their dining table not to eat certain items because they want to feed them to their dog.

08/26/2026 Resident was in the smoking area drunk, yelling and saying cruel things about staff. The resident made the other residents feel uncomfortable. When other residents asked them to stop, Resident 9 stated that they needed to say it and get it out. Resident 9 was very angry and loud.

In an interview on 08/27/2026 at 11:51 AM, Staff G, Resident Care Coordinator, confirmed the behavior support plan was not in Resident 9's medical chart available for staff to review. When asked how staff knew what interventions to use to support Resident 9, Staff G stated that they were unsure.

In an interview on 08/27/2026 at 11:57 AM, Staff A stated that they were unable to locate Resident 9's behavior support plan and would provide it for the department's review once it was located. The behavior support plan was provided to the department on 08/28/2026.

This is a recurring deficiency previously cited on 11/12/2025.

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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 :

(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 facility failed to ensure medications were received as prescribed, correct medication administration was documented and steps were taken when medications were not administered for 4 of 9 residents (Resident 1, 3, 4, and 5). This placed residents at risk of health complications when missed medications and administration errors were not identified and addressed in a timely manner.

Findings included…

Review of the facility's titled "Medication Administration Policy", dated 12/2024, showed that the facility will provide safe administration of all medications. Further review showed that the administration of a medication is to be documented on the Medication Administration Record (MAR) as soon as the medication is given and that medications that are not administered are to be documented using the correct response on the MAR.

<No Documentation of Administration>

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- Resident 1

Review of Resident 1's Service Evaluation/Negotiated Service Plan (the facility's combined assessment and negotiated service agreement), dated 10/30/2025, showed that they received medication assistance.

Review of Resident 1's undated Face Sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 1's June and August 2026 Medication Administration Records (MARs) showed that the following medications were ordered to be administered daily. Further review showed blanks on the following dates with no explanation as to why the medications were not given:

levothyroxine (thyroid medication): 06/17/2026 and 06/18/2026
Eliquis (blood thinner): 08/19/2026
diltiazem (for high blood pressure and chest pain): 08/19/2026
furosemide (for water retention and high blood pressure): 08/15/2026

- Resident 3

Review of Resident 3's Service Evaluation/Negotiated Service Plan, dated 04/09/2026, showed that the resident had a mild cognitive impairment and high blood pressure, and that the facility provided medication assistance.

Review of Resident 3's June, July and August 2026 MARs showed that the resident was prescribed atenolol (medication for high blood pressure, BP), with an order to hold the medication if the systolic (top number of BP measurement) was below 110 or the heart rate (HR) was below 60.

Review of the June 2026 MAR showed 14 days on which the atenolol had been noted with an X where the BP and HR measurements should have been documented. On eight of the 14 days, the medication was documented as not administered. The other six days were documented as administered, despite no BP or HR noted. Further review showed two additional days when the BP and HR were documented, but the atenolol was administered and not held, despite the BP and HR falling outside the parameters.

Review of the July 2026 MAR showed seven days on which the atenolol had been noted with an X where the BP and HR measurements should have been documented. Further review showed six additional days when the BP and HR were documented, but the atenolol was administered and not held, despite the BP and HR falling outside the

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parameters.

Review of the August 2026 MAR showed eight days on which the atenolol had been noted with an X where the BP and HR measurements should have been documented. On four of the eight days, the medication was documented as not administered. The other four days were documented as administered, despite no BP or HR noted. Further review showed two additional days when the BP and HR were documented, but the atenolol was administered and not held, despite the BP and HR falling outside the parameters.

- Resident 4

Review of Resident 4's undated Face Sheet showed diagnoses of [redacted] and [redacted]

Review of Resident 4's Service Evaluation/Negotiated Service Plan, dated 05/18/2026, showed that Resident 4 required medication assistance.

Review of Resident 4's June 2026 MAR showed a blank entry for each of the following medications on 06/21/2026: Doxepin (a medication administered once daily for insomnia), Latanoprost Ophthalmic solution (eyedrops administered once daily for glaucoma), Olanzapine (an antipsychotic administered once daily), Prazosin (a medication administered once daily for nightmares), and Propranolol (a medication administered twice a day for hypertension).

Review of the Resident 4's June 2026 Progress Notes showed no notes identifying or explaining why the medications were not documented as administered.

- Resident 5

Review of Resident 5's undated Face Sheet showed diagnoses of [redacted], and [redacted]

Review of Resident 5's Service Evaluation/Negotiated Service Plan, dated 11/17/2025, showed that Resident 5 required assistance with medications and treatments.

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Review of Resident 5's June, July, and August 2026 MARs showed the following blank entries:
Clonidine (used to treat hypertension): 06/28/2026
Prednisone acetate Ophthalmic Suspension (eyedrops to treat macular degeneration): 06/05/2026, 06/19/2026, 06/28/2026, 07/04/2026, 08/07/2026, 08/21/2026
Tamsulosin (used to treat benign prostatic hyperplasia, an enlarged prostate): 06/28/2026
Trazadone (sleep aid): 06/28/2026
Cyclosporine Ophthalmic Emulsion (eyedrops to treat macular degeneration): 06/28/2026 (1 of 2 doses)
Hydroxyzine Pamoate (used to treat anxiety): 06/28/2026 (1 of 3 doses)

In an interview on 08/28/2026 at 11:52 PM Staff A, Executive Director, stated that staff had not been documenting medications not administered in the progress notes and acknowledged that staff training about documentation was needed.

In an interview on 08/28/2026 at 2:36 PM, Staff A stated that blanks in the MAR meant that "someone didn't do their job" and that they didn't know whether the medications were administered.

In an interview on 09/01/2026 at 11:10 AM, Staff G, Resident Care Coordinator, stated that they conducted a MARs audit once a month "on a couple of people." Staff G further stated that the medication technicians verbally communicated who had refused medications and that they [the medication technicians] should have written in the progress notes about missing or refused medications. Staff G acknowledged that they did not have a consistent system that provided them current data about medications that had not been administered and relied on the monthly audits to catch missed medications, errors or other medication issues. Staff G acknowledged they could not respond or investigate missed medications unless the resident happened to be one of the couple residents selected for the monthly audits, and that the audit may take place weeks after the blank or 'x' was entered on the MAR.

<Missed Medications and Medication Pass>

Review of Resident 4's undated Face Sheet showed diagnoses of [redacted] and [redacted].

Review of Resident 4's Service Evaluation/Negotiated Service Plan, dated 05/18/2026, showed that the resident required medication assistance. Further review showed that the primary care provider (PCP) was to be informed if Resident 4 missed multiple medications or medication passes.

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Review of Resident 4's June, July, and August 2026 MARs showed that the resident was not administered the following medications on the following dates due to being out of the facility without medications:

Leovthyroxine Sodium (a medication used to treat hypothyroidism): 06/22/2026, 07/04/02026, 07/26/2026, 07/27/2026, 07/28/2026, 07/29/2026

Losartan Potassium (a medication used to treat hypertension): 06/22/2026, 06/28/2026, 07/04/2026, 07/25/2026, 07/26/2026, 07/27/2026, 07/29/2026, 07/30/2026, 08/13/2026

metformin (a medication used to treat diabetes): 06/22/2026, 06/28/2026, 07/04/2026, 07/25/2026, 07/26/2026, 07/27/2026, 07/29/2026, 07/30/2026, 08/13/2026

potassium chloride (a medication used to treat low potassium): 06/22/2026, 06/28/2026, 07/04/2026, 07/25/2026, 07/26/2026, 07/27/2026, 07/29/2026, 07/30/2026, 08/13/2026

Trelegy Ellipta (an inhaler used to treat COPD): 06/22/2026, 07/04/2026, 07/26/2026, 07/27/2026, 07/28/2026, 07/29/2026

furosemide (a medication used to treat hypertension): 06/22/2026 (2 of 2 doses), 06/28/2026 (1 of 2 doses), 07/04/2026 (2 of 2 doses), 07/25/2026 (2 of 2 doses), 07/26/2026 (2 of 2 doses), 07/27/2026 (2 of 2 doses), 07/29/2026 (1 of 2 doses), 07/30/2026 (1 of 2 doses), 08/13/2026 (1 of 2 doses)

Propranolol: 06/22/2026 (1 of 2 doses), 06/28/2026 (1 of 2 doses), 07/04/2026 (2 of 2 doses), 07/25/2026 (2 of 2 doses), 07/26/2026 (2 of 2 doses), 07/27/2026 (1 of 2 doses), 07/28/2026 (1 of 2 doses), 07/29/2026 (2 of 2 doses), 07/30/2026 (1 of 2 doses), 08/13/2026 (1 of 2 doses)

Gabapentin (a medication used to treat pain): 06/22/2026 (2 of 3 doses), 06/28/2026 (1 of 3 doses), 07/04/2026 (3 of 3 doses), 07/25/2026 (3 of 3 doses), 07/26/2026 (3 of 3 doses), 07/27/2026 (2 of 3 doses), 07/28/2026 (1 of 3 doses), 07/29/2026 (3 of 3 doses), 07/30/2026 (1 of 3 doses), 08/13/2026 (1 of 3 doses)

Olanzapine: 07/04/2026, 07/25/2026, 07/26/2026, 07/28/2026, 07/29/2026

Doxepin: 07/04/2026, 07/25/2026, 07/26/2026, 07/28/2026, 07/29/2026

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Latanoprost Ophthalmic solution: 07/04/2026, 07/25/2026, 07/26/2026, 07/28/2026, 07/29/2026

Prazosin: 07/04/2026, 07/25/2026, 07/26/2026, 07/28/2026, 07/29/2026

Rosuvastatin Calcium (a medication used to treat cholesterol): 08/13/2026

In an interview on 08/28/2026 at 11:12 AM, Staff H, Medication Technician, stated that Resident 4 had frequently left the facility for the day without notifying staff.

In an interview on 09/01/2026 at 11:11 AM, Staff G stated that they were aware that Resident 4 had a pattern of leaving the facility without notifying staff which prevented staff from sending their medications with them. When asked how they were made aware when Resident 4 missed multiple medications or a medication pass, Staff G further stated that the facility did not have a consistent system that alerted them to medications that were not administered. Staff G stated they, along with Staff A, conducted monthly audits of the MARs but acknowledged that the audits were limited to “a couple residents” and spaced too far apart to allow for a timely response.

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, Cherrywood Care 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-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

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(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(4) The plan for family assistance with medications or treatments must be signed and dated by:

(a) The resident, if able;

(b) The resident's representative, if any;

(c) The resident's family member responsible for implementing the plan; and

(d) A representative of the assisted living facility authorized by the assisted living facility to sign on its behalf.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a written plan for family members to assist with medication was completed for 1 of 1 resident (Resident 3). This failure placed the resident at risk of not receiving medications as ordered in a timely manner.

Findings included…

<Resident 3>

Review of Resident 3's Service Evaluation/Negotiated Service Plan (the facility's combined assessment and negotiated service agreement), dated 04/09/2026, showed that the resident had mild cognitive decline, diabetes, and that the facility provided medication assistance and ordered the medications.

Review of Resident 3's August 2026 Progress Notes showed the following:

08/13/2026: no Jardiance (used to treat diabetes) in stock, resident stated they are going to pick up more at the pharmacy later today.

08/24/2026: let family know about insulin (used to treat diabetes) running low.

08/27/2026: contacted family to bring in insulin as the last vile had been opened.

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As of 08/28/2026, record review showed there was not a written family assistance plan in the resident's records.

In an interview on 08/27/2026 at 1:24 PM, Collateral Contact 2, Resident 3's Emergency Contact, stated that they and other family members, ordered and delivered all of Resident 3's medications.

In an interview on 08/28/2026 at 3:48 PM, Staff A, Executive Director, confirmed they did not have a family assistance with medications plan for Resident 3.

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, Cherrywood Care 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

This document was prepared by Residential Care Services for the Locator website.