



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

CRH Chandler House LLC
Chandler House
701 N 39th Ave
Yakima, WA 98902

RE: Chandler House License # 2156

Dear Administrator:

This letter addresses Compliance Determination(s) 59421 (Completion Date 05/15/2025) and 56412 (Completion Date 03/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/15/2025 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-2210-1-b, WAC 388-78A-2210-2-b, WAC 388-78A-2240, WAC 388-78A-2930-1-a, WAC 388-78A-2930-1-a-i, WAC 388-78A-2930-1-a-ii, WAC 388-78A-2930-1-a-iii, WAC 388-78A-2930-1-b-i, WAC 388-78A-2930-1-b-ii, WAC 388-78A-2930-1-b, WAC 388-78A-2930-1-c, WAC 388-78A-2930-1

The Department staff who did the on-site verification:
Jessica Clapp, Assisted Living Facility Licensor

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

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



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 #: 2156	Compliance Determination # 56412
Plan of Correction	Chandler House	Completion Date
Page 1 of 10	Licensee: CRH Chandler House LLC	03/21/2025

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 03/17/2025, 03/18/2025 and 03/19/2025 of:

Chandler House
701 N 39th Ave
Yakima, WA 98902

This document references the following complaint numbers: 168797, 168418.

The following sample was selected for review during the unannounced on-site visit: 7 of 34 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor

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

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Statement of Deficiencies	License #: 2156	Compliance Determination # 56412
Plan of Correction	Chandler House	Completion Date
Page 2 of 10	Licensee: CRH Chandler House LLC	03/21/2025

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.

Laura Williams-Davis
Residential Care Services

03/26/2025
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.

Aurette Dawson

Administrator (or Representative)

4/2/25

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 :
 - (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure that safe medication services were provided for 2 of 7 residents (Resident 1 and 2). This failure placed residents at risk of not being given their prescription medication as prescribed.

<Resident 1>

Review of Resident 1's full facility assessment and Negotiated Service Agreement (NSA), dated 02/28/2025, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. Resident 1's assessment showed that the resident required staff to provide medication administration.

Review of Resident 1's physician order, dated 12/20/2024, showed that the resident had

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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.

Laura Williams-Davis
Residential Care Services

03/26/2025
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

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- (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 :
- (b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility failed to ensure that safe medication services were provided for 2 of 7 residents (Resident 1 and 2). This failure placed residents at risk of not being given their prescription medication as prescribed.

<Resident 1>

Review of Resident 1's full facility assessment and Negotiated Service Agreement (NSA), dated 02/28/2025, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. Resident 1's assessment showed that the resident required staff to provide medication administration.

Review of Resident 1's physician order, dated 12/20/2024, showed that the resident had

an order for trazodone (a medication used for insomnia), to be given every night at bedtime.

Review of Resident 1's December 2024 Medication Administration Record (MAR), showed that the resident was prescribed trazodone. Resident 1's MAR did not show documentation that the resident received their medication between 12/23/2024 through 12/31/2024.

Review of Resident 1's January 2025 MAR, showed that showed that the resident was prescribed trazodone. Resident 1's MAR did not show documentation that the resident received their medication between 01/01/2025 through 01/09/2025 and between 01/11/2025 through 01/16/2025. Additionally, Resident 1's MAR showed two administration times of 12:00 AM and bedtime.

In an interview on 03/19/2025 at 10:00 AM, Collateral Contact 1 (CC1), resident representative, stated that Resident 1 had taken their trazodone medication for a "Long time" and that it had been a routine medication for the resident. Additionally, CC1 stated that there had been several nights in the past few months that Resident 1 had not slept.

In an interview on 03/20/2025 at 11:39 AM, Staff G, Licensed Practical Nurse/Director of Nursing, stated that Resident 1 had been receiving their trazodone medication. Additionally, Staff G, acknowledged that Resident 1's January 2025 MAR showed two administration times of 12:00 AM and bedtime. Staff G stated that the two administration times were due to a discrepancy and that there was a mistake made on the MAR.

In an interview on 03/20/2025 at 1:42 PM, Staff G, stated that they had approved Resident 1's trazodone routine medication as a PRN (as needed) medication on Resident 1's MAR. Staff G stated that they had a verbal conversation with Resident 1's provider regarding their trazodone medication being used as needed. Additionally, Staff G stated that they did not review the provider's note that showed Resident 1's trazodone was ordered as a routine dose.

<Resident 2>

Review of Resident 2's full facility assessment and NSA, dated 03/10/2025, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. Resident 2's assessment showed that the resident required staff to provide medication administration.

Review of Resident 2's physician order, dated 03/08/2025, showed that they had an order for verapamil (medication for high blood pressure), to be given once daily.

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Review of Resident 2's March 2025 Medication Administration Record (MAR), showed two entries for the verapamil. The first entry, that matched the physician order, showed the medication was started on 03/01/2025 and was scheduled to be given once daily at bedtime. This entry was discontinued on 03/10/2025. The second entry showed the medication order was started on 03/10/2025 and showed medication administration times of 12:00 AM to 10:59 AM, a second administration time of 12:00 AM to 10:59 AM, a third administration time of 1:59 PM to 6:59 PM, and a fourth administration time of bedtime. The second entry did not match the physician order and remained on the March 2025 MAR.

In an interview on 03/20/2025 at 12:06 PM, Staff G, acknowledged that Resident 2's MAR had four administration times for the medication that was to be given once daily.

On 03/20/2025 at 2:00 PM, CC2, pharmacy staff, stated that the pharmacy receives an order from the prescriber, their system auto populates the order, and the order is sent electronically to the facility for review. Additionally, CC2 stated that the facility would then review and approve, deny, or change the specific administration times.

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, Chandler House is or will be in compliance with this law and / or regulation on (Date) <u>3/15/25</u> .	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
Administrator (or Representative) <u><i>Myrette Samson</i></u>	Date <u>4/3/25</u>

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 interview and record review, the Assisted Living Facility failed to ensure that resident medications were obtained when staff were responsible to order medications, for 2 of 7 residents (Residents 3 and 4). This failure placed the residents at risk for a decline in their chronic health conditions.

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Review of Resident 2's March 2025 Medication Administration Record (MAR), showed two entries for the verapamil. The first entry, that matched the physician order, showed the medication was started on 03/01/2025 and was scheduled to be given once daily at bedtime. This entry was discontinued on 03/10/2025. The second entry showed the medication order was started on 03/10/2025 and showed medication administration times of 12:00 AM to 10:59 AM, a second administration time of 12:00 AM to 10:59 AM, a third administration time of 1:59 PM to 6:59 PM, and a fourth administration time of bedtime. The second entry did not match the physician order and remained on the March 2025 MAR.

In an interview on 03/20/2025 at 12:06 PM, Staff G, acknowledged that Resident 2's MAR had four administration times for the medication that was to be given once daily.

On 03/20/2025 at 2:00 PM, CC2, pharmacy staff, stated that the pharmacy receives an order from the prescriber, their system auto populates the order, and the order is sent electronically to the facility for review. Additionally, CC2 stated that the facility would then review and approve, deny, or change the specific administration times.

Plan/Attestation Statement

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Administrator (or Representative)

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 interview and record review, the Assisted Living Facility failed to ensure that resident medications were obtained when staff were responsible to order medications, for 2 of 7 residents (Residents 3 and 4). This failure placed the residents at risk for a decline in their chronic health conditions.

Findings included...

<Resident 3>

Review of Resident 3's full facility assessment and Negotiated Service Agreement (NSA), dated 01/09/2025, showed that the resident had diagnoses of [REDACTED] and [REDACTED]. Additionally, Resident 3's assessment showed that the resident required staff to provide medication administration.

Review of Resident 3's physician order, dated 07/11/2024, showed that the resident had an order for lisinopril (medication for high blood pressure) to be given daily. Additionally, Resident 3's physician order, dated 08/06/2024, showed that they had an order for quetiapine (medication to treat mood disorders) 100 milligrams (mg) to be given daily every morning and an order for quetiapine 200 mg to be given daily at bedtime.

Review of Resident 3's January 2025 MAR, showed that the resident did not receive their lisinopril medication on 01/02/2025, 01/03/2025 and on 01/07/2025. Resident 3's MAR showed that from 01/01/2025 through 01/07/2025, the resident did not receive their quetiapine 100 mg medication. Additionally, Resident 3's MAR showed that on 01/04/2025 and 01/05/2025, the resident did not receive their quetiapine 200 mg medication. The MAR showed the reason as "Med not available," for the resident not receiving their lisinopril and quetiapine medications.

Review of Resident 3's progress note, dated 01/03/2025, showed that the resident paced and had hallucinations.

Review of Resident 3's progress notes, dated 01/05/2025, showed that the resident had increased hallucinations.

In an interview on 03/19/2025 at 2:48 PM, Staff G, Licensed Practical Nurse/Director of Nursing, acknowledged that Resident 3 did not have their lisinopril medication from 01/01/2025 through 01/03/2025 and their quetiapine medications from 01/01/2025 through 01/06/2025.

<Resident 4>

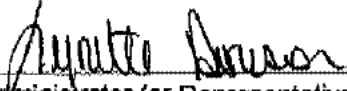
Review of Resident 4's full facility assessment and NSA, dated 10/07/2024, showed that the resident had a diagnosis of [REDACTED]. Additionally, Resident 4's assessment showed that the resident required staff to provide medication administration.

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Review of Resident 4's physician order, dated 03/19/2025, showed that the resident had an order for memantine (medication for dementia symptoms) to be given twice daily.

Review of Resident 4's January 2025 MAR, showed that the resident missed 7 doses of their memantine medication from 01/05/2025 through 01/09/2025.

In an interview on 03/20/2025 at 9:53 AM, Staff G, stated that Resident 4 had run out of their medication on 01/05/2025 and that they did not have their medication available until 01/09/2025. Staff G stated that they did not know why Resident 4's medication had not been ordered before their supply ran out.

Plan/Attestation Statement	
<p>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, Chandler House is or will be in compliance with this law and / or regulation on (Date) <u>5/15/25</u>.</p>	
<p>In addition, I will implement a system to monitor and ensure continued compliance with this requirement.</p>	
 _____ Administrator (or Representative)	<u>4/3/25</u> _____ Date

WAC 388-78A-2930 Communication system.

- (1) The assisted living facility must:
 - (a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:
 - (i) Bathrooms and toilet rooms;
 - (ii) Resident living rooms and resident sleeping rooms; and
 - (iii) Corridors, as well as common and outdoor areas accessible to residents.
 - (b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident's sleeping room, and when wireless communications are used:
 - (i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and
 - (ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

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Review of Resident 4’s physician order, dated 03/19/2025, showed that the resident had an order for memantine (medication for dementia symptoms) to be given twice daily.

Review of Resident 4’s January 2025 MAR, showed that the resident missed 7 doses of their memantine medication from 01/05/2025 through 01/09/2025.

In an interview on 03/20/2025 at 9:53 AM, Staff G, stated that Resident 4 had run out of their medication on 01/05/2025 and that they did not have their medication available until 01/09/2025. Staff G stated that they did not know why Resident 4’s medication had not been ordered before their supply ran out.

Plan/Attestation Statement	
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<p>In addition, I will implement a system to monitor and ensure continued compliance with this requirement.</p>	
<p>_____</p> <p>Administrator (or Representative)</p>	<p>_____</p> <p>Date</p>

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:

(a) Provide residents and staff persons with the means to summon on-duty staff assistance from all resident-accessible areas including:

- (i) Bathrooms and toilet rooms;
- (ii) Resident living rooms and resident sleeping rooms; and
- (iii) Corridors, as well as common and outdoor areas accessible to residents.

(b) Provide the resident with personal wireless communication devices, such as pendants or wristbands, when a communication device is not installed in the resident’s sleeping room, and when wireless communications are used:

- (i) The system must be designed and installed consistent with industry standards and perform reliably throughout the facility; and
- (ii) The facility must have a policy and procedure describing the mitigating measures in the event of system disruption, including for maintenance and loss of power; and

(c) Provide residents, families, and other visitors with a means to contact a staff person inside the building from outside the building after hours.

This requirement was not met as evidenced by:

Based on observation and interview the facility failed to ensure that residents had a method to communicate with staff when they needed assistance in 4 of 4 Cottages (Houses A, B, C and D) for 7 of 7 residents (Resident 1, 2, 3, 4, 5, 6, and 7). This failure placed residents at risk of unmet care needs when they could not call staff for assistance.

Findings included...

Review of the characteristic roster, undated, showed that there were 36 licensed beds in the memory care unit.

House A

Observation on 03/17/2025 at 10:20 AM, showed that House A's living room, dining room and the three bathrooms did not have a communication system in place for residents to call staff when they required assistance.

<Resident 2>

Review of Resident 2's facility assessment and NSA, dated 03/10/2025, showed that the resident had medical conditions that included dementia with Lewy body (brain disease that effects thinking, movement, mood, and behavior), depression, and hallucinations. The document showed that Resident 2 required standby assistance for toileting, mobility, and transfers.

Observation on 03/18/2025 at 11:57 AM, showed that Resident 2 was seated in the dining room in House A. Resident 2 did not have a communication system in place that would enable them to call staff when they needed assistance.

House B

Observation on 03/17/2025 at 10:33 AM, showed that House B's living room, dining room and the three bathrooms did not have a communication system in place for residents to call staff when they required assistance.

<Resident 1>

Review of Resident 1's facility assessment and Negotiated Service Agreement (NSA), dated 02/28/2025, showed that the resident had medical conditions the included dementia, anxiety, and insomnia. The document showed that Resident 1 required two staff to assist them for toileting, mobility (ability to move from place to place), and transfers (ability to move from chair to bed).

Observation on 03/19/2025 at 3:29 PM, showed that Resident 1's room in House B did not have a communication system that would enable the resident to call staff when they needed assistance.

<Resident 5>

Review of Resident 5's facility assessment and NSA, dated 09/16/2024, showed that the resident had medical conditions that included dementia, anxiety and behaviors. The document showed that Resident 5 required extensive assistance with personal hygiene, toileting and required assistance for mobility and transfers.

Observation on 03/19/2025 at 10:21 AM, showed that Resident 5 was seated in a recliner in the living room of House B and there were five other residents in area. Observation showed that the living room did not have a communication system in place that enabled Resident 5, and the other residents, to contact staff when they required assistance. Additionally, observation showed that facility staff was in the kitchen completing other tasks.

House C

Observation on 03/17/2025 at 11:00 AM, showed that House C's living room, dining room and the three bathrooms did not have a communication system in place for residents to call staff when they required assistance.

<Resident 7>

Review of Resident 7's facility assessment and NSA, dated 09/29/2024, showed that the resident had medical conditions that included dementia, pain and anxiety. The document showed that Resident 7 required staff assistance with personal hygiene, dressing and that the resident required daily monitoring. The document showed that Resident 7, "may require help" with personal care when toileting.

Observation on 03/17/2025 at 10:10 AM, showed that Resident 7's room in House C did not have a communication system in place that enabled them to contact staff when they required assistance.

In an interview on 03/21/2025 at 10:07 AM, Collateral Contact 3 (CC3), Resident 7's Representative, stated that the resident did not have a communication system available to them at the facility. CC3 stated that Resident 7 had falls in their room and that the resident had to yell, "help me" to get staff assistance. CC3 stated when Resident 7 lived at home they used a bell to call family for assistance and stated that the resident would probably use a communication system if it was available at the facility.

<Resident 4>

Review of Resident 4's facility assessment and NSA, dated 10/07/2024, showed that the resident had medical conditions that included dementia, depression, and atrial fibrillation (irregular heartbeat). The document showed that Resident 4 required two staff to assist them with toileting, bathing, mobility, and transfers. Additionally, Resident 4's document showed that the resident required three staff to assist at times for transfers and that a mechanical lift may also be utilized.

Observation on 03/18/2025 at 8:48 AM, showed that Resident 4 was seated in a recliner in the living room of House C. Resident 4 did not have a communication system in place that would enable them to call staff when they needed assistance. Additionally, facility staff were not present in the area.

<Resident 6>

Review of Resident 6's facility assessment and NSA, dated 01/13/2025, showed that the resident medical conditions that included dementia, chronic pain, and neuropathy (condition where nerve damage leads to pain, numbness and weakness). The document showed that Resident 6 required extensive assistance with personal hygiene, toileting every two hours, dressing and mobility and transfers. The assessment showed that Resident 6 required frequent guidance, direction and reassurance from staff.

Observation on 03/18/2025 at 11:10 AM, showed that Resident 6's room in House C did not have a communication system that enabled them to contact staff when they required assistance.

House D

Observation on 03/17/2025 at 11:03 AM, showed that House D's living room, dining room and the two bathrooms did not have a communication system in place for residents to call staff when they required assistance.

<Resident 3>

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Review of Resident 3's facility assessment and NSA, dated 01/09/2025, showed that the resident had medical conditions that included dementia, high blood pressure, and vision impairment. The document showed that Resident 3 required set up and hands on assistance with all hygiene and standby assistance due to vision impairment for mobility and transfers.

Observation on 03/18/2025 at 4:00 PM, showed that Resident 3 was seated in a wheelchair in the living room of House D. Resident 3 did not have a communication system in place to call staff when they needed assistance. Additionally, observation showed that there was not a staff member present in the area.

In an interview on 03/19/2025 at 11:30 AM, Staff H, Administrator, stated that each house had a portable phone for staff-to-staff communication. Staff H stated that the residents at the facility did not have a communication system in place to call for staff assistance.

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, Chandler House is or will be in compliance with this law and / or regulation on (Date) <u>4/2/25</u>	
In addition, I will implement a system to monitor and ensure continued compliance with this requirement.	
<u>Ayatta Dawson</u> Administrator (or Representative)	<u>4/3/25</u> Date

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Review of Resident 3’s facility assessment and NSA, dated 01/09/2025, showed that the resident had medical conditions that included dementia, high blood pressure, and vision impairment. The document showed that Resident 3 required set up and hands on assistance with all hygiene and standby assistance due to vision impairment for mobility and transfers.

Observation on 03/18/2025 at 4:00 PM, showed that Resident 3 was seated in a wheelchair in the living room of House D. Resident 3 did not have a communication system in place to call staff when they needed assistance. Additionally, observation showed that there was not a staff member present in the area.

In an interview on 03/19/2025 at 11:30 AM, Staff H, Administrator, stated that each house had a portable phone for staff-to-staff communication. Staff H stated that the residents at the facility did not have a communication system in place to call for staff assistance.

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