STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

HSRE-PMB II TRS, LLC
GenCare Lifestyle Tacoma at Point Ruston
4970 Main St
Tacoma, WA 98407

RE: GenCare Lifestyle Tacoma at Point Ruston License # 2557

Dear Administrator:

This letter addresses Compliance Determination(s) 45598 (Completion Date 08/13/2024) and 41747 (Completion Date 06/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/13/2024 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-2410-9, WAC 388-78A-2410-10

The Department staff who did the on-site verification:
Kathy Heinz, Long Term Care Surveyor

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GenCare Lifestyle Tacoma at Point Ruston
Provider Type: Assisted Living Facility
License/Cert.#: 2557
Intake ID: 117939
Compliance Determination #: 41747
Region/Unit #: RCS Region 3 / Unit D
Investigator: Kathy Heinz
Investigation Date(s): 05/23/2024 through 06/25/2024
Complainant Contact Date(s): 05/23/2024

Allegation(s):
Identified Resident (IR) did not receive timely medical care.

Investigation Methods:

Sample:	Total residents: 84 Resident sample size: 2 Closed records sample size: 1
Observations:	Resident rooms Staff to resident interactions Residents
Interviews:	Wellness Director Licensed Staff Memory Care Director
Record Reviews:	Physician Orders Medical records Personnel files Lab results Care plans Progress Notes Treatment Records Medication Administration Records

Investigation Summary:
Based on interview and record reviews, the facility failed to document in the resident record, staff interventions and well being of one of three Residents. A citation was written under 388-78A- 2410.

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 #: 2557	Compliance Determination # 41747
Plan of Correction	GenCare Lifestyle Tacoma at Point Ruston	Completion Date
Page 1 of 3	Licensee: HSRE-PMB II TRS, LLC	06/25/2024

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 05/23/2024, 05/24/2024, 06/17/2024, 06/25/2024 and 06/25/2024 of:

GenCare Lifestyle Tacoma at Point Ruston
4970 Main St
Tacoma, WA 98407

This document references the following complaint number(s): 117939

The following sample was selected for review during the unannounced on-site visit: 2 of 84 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Kathy Heinz, Long Term Care Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

07/01/2024
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.

Administrator (or Representative)

7/9/2024
Date

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

(10) Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on interviews and records review, the facility failed to document staff interventions and the wellbeing for 1 of 3 Residents (Resident 1) when a physician ordered two diagnostic tests to be completed. This failure placed Resident 1 at risk for decline in their health status.

Findings included...

Test 1

During an interview on 06/11/2024 at 1:00 PM, CC1 said they had concerns Resident 1 (R1) did not get a urinalysis (a common test that analyzes the specimens in your urine, UA) completed in a timely manner. CC 1 asked staff to get a UA because R1's urine smelled "pungent." CC 1 said staff did not respond to her request and CC1 requested the order for the UA from the physician.

Review of a facsimile (FAX) dated 12/05/2023 showed R1's physician ordered a UA. Staff D, Licensed Nurse, documented on 12/13/2023, the urine was collected and sent to a laboratory (lab) for analysis.

Review of the UA from the lab, dated 12/15/2023, showed the urine was collected on 12/12/2023 (seven days after the order was written), received by the laboratory on 12/14 /2023, resulted on 12/14/2023, and the report was prepared on 12/15/2023. The results of the report showed R1 had a urinary tract infection (an infection in any part of the urinary system, UTI). Staff B, Wellness Director, noted the results.

Review of R1's Medication Administration Record (MAR) dated December 2024, showed a physician order for Nitrofurantoin (antibiotic used to treat a UTI) with a start date of

12/15/2023. R1 received one dose of the antibiotic before she was sent out to a local hospital for evaluation.

Staff D , Licensed Practical Nurse (LPN) was interviewed on 05/25/2024 at 12:00 PM. Staff D said there were no notes documenting staff attempted to collect urine between 12/05/2023 and 12/12/2023.

Test 2

CC1 said during an interview on 06/11/2024 at 1:00 PM, families were allowed to visit in the memory care unit following a closure of the unit for COVID on 12/12/2023. CC1 said R1 appeared very ill. CC1 requested an order for a chest x-ray from R1's physician.

Review of a FAX sent to the facility dated 12/12/2023 showed R1's physician ordered a chest x-ray to be completed urgently. Review of a FAX dated 12/12/2023 showed the results of the chest x-ray. On 12/13/2023, R1's physician ordered Levofloxacin (antibiotic used to treat infection and Furosemide (diuretic for water retention).

There was no documentation related to the infection in R1's progress notes or treatment record on 12/12/2023 and 12/13/2023.

CC1 said on 06/11/2024 R1 was hospitalized on [redacted]/2023 and had UTI and pneumonia.

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, GenCare Lifestyle Tacoma at Point Ruston is or will be in compliance with this law and / or regulation on (Date) 8/9/24 .

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

Administrator (or Representative) — 7/9/24 Date

Plan of Correction
GenCare Lifestyle Tacoma at Point Ruston
License # 2557
Statement of Deficiencies Completion Date August 9, 2024

Citation #1

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a form that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

(9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.

(10) Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.

Correction:

(a) Wellness Director created a new treatment order and temporary care plan to ensure tracking of new lab work requests to ensure documentation of interventions. (Attached)

(b) Wellness Director performed In-Service training with the Wellness Nurses to ensure their understanding of the new order and temporary care plan. (Attached)

Monitoring:

During weekly clinical meetings, the Wellness Nurses will discuss the progress of lab work requests with the team. The Wellness Director will add this new topic to the agenda of the clinical meetings.