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

Lasting Harmony LLC
Legacy Adult Family Homes LLC
404 N Conway St
Kennewick, WA 99336

RE: Legacy Adult Family Homes LLC License # 755872

Dear Provider:

This letter addresses Compliance Determination(s) 45017 (Completion Date 08/02/2024) and 40349 (Completion Date 05/29/2024).

The Department completed a follow-up inspection of your Adult Family Home on 08/02/2024 and found that you have corrected the violations listed in the Complaint report dated 05/29/2024. Your home is back in compliance as of with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10750-1

The Department staff who did the on-site verification:
Michelle Closner, Complaint Nurse Field Manager

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit C
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 04/25/2024 and 04/25/2024 of:

Legacy Adult Family Homes LLC
2621 W Entiat Ave
Kennewick, WA 99336

This document references the following complaint number(s): 126564

The following sample was selected for review during the unannounced on-site visit: 2 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Sarah Clark, Community Complaint Investigator

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

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.

Michelle Closner
Residential Care Services

06/04/2024
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Statement of Deficiencies	License #: 755872	Compliance Determination # 40349
Plan of Correction	Legacy Adult Family Homes LLC	Completion Date
Page 2 of 3	Licensee: Lasting Harmony LLC	05/29/2024

Provider (or Representative)

6/14/24
Date

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, and homelike environment that is free of hazards;

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Adult Family Home (AFH) failed to ensure the facility's concrete entrance was safe and free from hazards for one of six residents (Resident 1) who used a wheelchair during an annual evacuation drill. This failure contributed to Resident 1's wheelchair rolling off the concrete slab, resulting in Resident 1 falling out of their wheelchair to fracture their ankle.

Findings Included...

During an interview on 4/25/2024 at 12:21 PM, Resident 1 stated that they were participating in an evacuation drill, were taken out the front door by staff and "parked" on the concrete walkway. Resident 1 stated that they ended up on the grass and rolled down the hill. Resident 1 could not recall if staff put their brakes on or if they (Resident 1) had taken them off.

Observation on 4/25/2024 at 12:14 PM, of the facility entrance, showed a concrete walkway and concrete entrance. The entrance was adjacent to a grassy incline that led down onto a concrete sidewalk. There was a fence that lined the concrete pathway separating it from the grass incline.

During an interview on 04/25/2024 at 12:41 PM, Staff A, Caregiver, stated during the evacuation drill on 4/10/2024, they had wheeled Resident 1 out of the facility entrance, onto the concrete walkway, put their brakes on, and then turned to evacuate another resident. When they turned back around Resident 1 had unlocked their brakes, was wheeling/turning to the edge of the concrete and started to go down the grassy incline. Staff A, attempted, but was unsuccessful to reach Resident 1 before they rolled the entire way down the grass incline and fell out of their wheelchair onto the sidewalk. The AFH determined that Resident 1 needed further medical evaluation. Staff A further stated this was their first time doing an evacuation drill out the front door as they normally do their other drills "out the back."

Review of Resident 1's admission assessment, dated 8/04/2023, showed Resident 1 had dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). They made safe decisions in familiar situations and experienced some difficulty in new situations, and that they could consistently and safely use the

Provider (or Representative) _____ Date _____

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(1) Keep the home both internally and externally in good repair and condition with a safe, comfortable, sanitary, and homelike environment that is free of hazards;

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During an interview on 4/25/2024 at 12:21 PM, Resident 1 stated that they were participating in an evacuation drill, were taken out the front door by staff and "parked" on the concrete walkway. Resident 1 stated that they ended up on the grass and rolled down the hill. Resident 1 could not recall if staff put their brakes on or if they (Resident 1) had taken them off.

Observation on 4/25/2024 at 12:14 PM, of the facility entrance, showed a concrete walkway and concrete entrance. The entrance was adjacent to a grassy incline that led down onto a concrete sidewalk. There was a fence that lined the concrete pathway separating it from the grass incline.

During an interview on 04/25/2024 at 12:41 PM, Staff A, Caregiver, stated during the evacuation drill on 4/10/2024, they had wheeled Resident 1 out of the facility entrance, onto the concrete walkway, put their brakes on, and then turned to evacuate another resident. When they turned back around Resident 1 had unlocked their brakes, was wheeling/turning to the edge of the concrete and started to go down the grassy incline. Staff A, attempted, but was unsuccessful to reach Resident 1 before they rolled the entire way down the grass incline and fell out of their wheelchair onto the sidewalk. The AFH determined that Resident 1 needed further medical evaluation. Staff A further stated this was their first time doing an evacuation drill out the front door as they normally do their other drills "out the back."

Review of Resident 1's admission assessment, dated 8/04/2023, showed Resident 1 had dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). They made safe decisions in familiar situations and experienced some difficulty in new situations, and that they could consistently and safely use the

wheelchair. Resident 1 was non-weight bearing on their left foot and used a wheelchair.

Review of Negotiated Service Plan, dated 8/09/2023, showed they needed assistance for emergency evacuation and "staff were to assist Resident 1 into their wheelchair and push them into a safe area."

Record review of emergency room report, dated 4/10/2024, showed that Resident 1 had a fracture of the left ankle.

During an observation, on 5/02/2024 at 12:30 PM, Resident 1 was seen self-propelling their wheelchair, stopped to lock and unlock their brakes. Resident 1 had a walking boot on their left foot. During a subsequent interview Resident 1 stated they knew how to lock/unlock their brakes and could do it independently.

Observation on 5/2/2024 at 12:15 PM, of a demonstration by Staff A, Caregiver, showed that Resident 1 was placed away from the edge of the concrete during the evacuation drill, with their wheelchair brakes engaged.

During an interview on 4/25/2024 at 10:29 AM, Staff B, Licensed Practical Nurse, stated that "we had not seen Resident 1 outside in their wheelchair before". Staff B did not ever remember seeing Resident 1 outside alone. Staff B also stated, it was a "freak accident" and to make sure it didn't happen again, they put up the fence the next day.

During an interview on 5/02/2024 at 01:34 PM, Staff C, Provider, stated that the fence went up the next day, to ensure it didn't happen again.

During an interview on 4/25/224 at 02:17 PM, Collateral Contact 1, stated that they were disappointed that the facility would leave a demented resident on a sloping surface, even if they had their brakes on. and they put the fence up the next day.

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, Legacy Adult Family Homes LLC is or will be in compliance with this law and / or regulation on (Date) 6/14/24.

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

Provider (or Representative) — Date 6/14/24

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Observation on 5/2/2024 at 12:15 PM, of a demonstration by Staff A, Caregiver, showed that Resident 1 was placed away from the edge of the concrete during the evacuation drill, with their wheelchair brakes engaged.

During an interview on 4/25/2024 at 10:29 AM, Staff B, Licensed Practical Nurse, stated that “we had not seen Resident 1 outside in their wheelchair before”. Staff B did not ever remember seeing Resident 1 outside alone. Staff B also stated, it was a “freak accident” and to make sure it didn't happen again, they put up the fence the next day.

During an interview on 5/02/2024 at 01:34 PM, Staff C, Provider, stated that the fence went up the next day, to ensure it didn’t happen again.

During an interview on 4/25/224 at 02:17 PM, Collateral Contact 1, stated that they were disappointed that the facility would leave a demented resident on a sloping surface, even if they had their brakes on. and they put the fence up the next day.

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