Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 31252
Investigator: Maria Salas
Investigation Date(s): 10/18/2023 through 01/05/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 101047
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Allegations of physical and phycological abuse towards residents.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Identified resident
Interviews:	Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Grievance log State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
Based on record review and interview the facility failed to follow stated and facility policy and procedures for suspected and alleged abuse. The facility failed to verify staff references prior to employment. The facility failed to ensure required training for staff working in a dementia care unit. The facility failed to ensure resident right to be free from abuse. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 31252
Investigator: Maria Salas
Investigation Date(s): 10/18/2023 through 01/05/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 101823
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Allegations of physical and phycological abuse towards residents.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Identified resident
Interviews:	Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Grievance log State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
Based on record review and interview the facility failed to follow stated and facility policy and procedures for suspected and alleged abuse. The facility failed to verify staff references prior to employment. The facility failed to ensure required training for staff working in a dementia care unit. The facility failed to ensure resident right to be free from abuse. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: GARDEN COURTE ALZHEIMER COMMUNITY
License/Cert.#: 1111
Compliance Determination #: 31252
Investigator: Maria Salas
Investigation Date(s): 10/18/2023 through 01/05/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 104783
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
Allegations of physical abuse and restraining of resident.

Investigation Methods:

Sample:	Total residents: 80 Resident sample size: 4 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Identified resident
Interviews:	Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records Grievance log State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
Based on record review and interview the facility failed to follow stated and facility policy and procedures for suspected and alleged abuse. The facility failed to verify staff references prior to employment. The facility failed to ensure required training for staff working in a dementia care unit. The facility failed to ensure resident right to be free from abuse. Failed practice identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 10/18/2023 and 12/13/2023 of:

GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 101047, 99320, 99595, 101823, 99931, 102395, 104783

The following sample was selected for review during the unannounced on-site visit: 4 of 80 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 10/18/2023 and 12/13/2023 of:

GARDEN COURTE ALZHEIMER COMMUNITY
626 LILLY RD NE
OLYMPIA, WA 98506

This document references the following complaint number(s): 101047, 99320, 99585, 101823, 99931, 102398, 104783

The following sample was selected for review during the unannounced on-site visit: 4 of 80 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

01/17/2024
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) Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

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

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement facility policies and procedures when suspected abuse was reported for 2 of 2 residents (Resident 2 and Resident 3). These failures contributed to Resident 2 being placed at risk for on going harm and placed all 80 of 80 residents at risk of harm due to staff not following facility and state policies when suspected abuse had been reported.

Findings included…

WAC 388-78A-2020
“Definitions.
"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult… "Neglect" means: (1) A pattern of conduct or inaction resulting in the failure to provide the goods and services that maintain physical or mental health of a resident, or that fails to avoid or prevent physical or mental harm or pain to a resident; or (2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100..."Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or... ”Physical restraint" means the application of physical force without use of any device for the purpose of restraining the free movement of a vulnerable adult's body..."

Record review of the facility's Abuse Policy and Procedure, undated, showed that the purpose of the Abuse Policy and Procedure was to ensure that all residents were treated with respect, dignity and lived in a community that was free of verbal, sexual or physical abuse. To establish a procedure for investigating and documenting suspected or alleged abuse. To delineate state specific definitions and reporting requirements for alleged or suspected abuse. The policy stated that all allegations of abuse would be treated as serious and would be investigated, documented and reported per the standards set forth in the policy and procedure or per State or Federal regulations. Physical Abuse as defined in the Abuse Policy and Procedure was any physical injury to a resident caused by other than an accident. Physical injuries included injuries that a reasonable and prudent person would be able to prevent such as hitting, pinching or striking, or injuries resulting from rough handling or corporal punishment. Verbal or Emotional Abuse as defined in the Abuse Policy and Procedure was any oral, written or gestures communicated to a resident or to a visitor or staff about a resident within that resident's presence, that described that resident in a disparaging or derogatory terms, humiliation, harassment threats of punishment or deprivation directed towards the resident. Per the Abuse Policy and Procedure, the Administrator was to complete the investigation portion of the Incident/Accident report is abuse was suspected.

Review of the facility policy, titled, "Restraints and Enablers", undated, showed, "The use of restraints will not be used on any resident."

Record review of the facility Abuse Investigation and Reporting Aggressive & Assaultive Resident Policy, undated, showed that the facility had a zero-tolerance policy towards resident abuse, neglect, or mistreatment. Abuse or Neglect was defined in the policy as non-accidental physical injury or condition, sexual abuse, or neglect treatment of a resident under circumstances which indicate the resident's health, welfare, and safety is harmed. In addition to reporting suspected abuse or neglect to the DSHS (Department of Social and Health Services) Hotline, employees were also to report the situation to a Designated Person (the Administrator, the Assistant or the Health Service Coordinator)

Record review of the facility's policy Reporting Abuse, Neglect and Exploitation, undated, showed under section 1a, that any staff member who had a reasonable cause to believe that an incident of abuse, abandonment, neglect, or financial exploitation had occurred would notify the DSHS Complaint Resolution Unit (CRU) hotline. The staff member should have also reported concerns immediately to someone within management so that immediate interventions could take place. Section 1e, showed that any staff member who was suspected of abuse, neglect, or exploitation would not have access to any resident until the community investigated the incident and took action to assume the safety of the residents. Section 2 showed that an incident report would be prepared for any abuse, neglect, or exploitation to determine the circumstances of the event and to determine appropriate measures to prevent similar future situations. Section 6, showed it was the responsibility of each staff member to immediately contact the department directly regarding suspected or alleged abuse or other improprieties.

Record review of the facility's Abuse Allegation and Investigation Policy, undated, showed that in an investigation of abuse the resident would be interviewed.

Record review of department document Assisted Living Facility Guidebook, dated 02/2018, showed in Appendix F that in general there was a presumption that abuse had occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive, or unwanted contact with a resident. This presumes that instances of abuse of any resident causes physical harm, pain, or mental anguish.

In an interview on 10/18/2023 at 11:33am, Staff A, Caregiver, stated that she witnessed Staff B, Caregiver, taunting and yelling at a male resident to hit her. Staff A stated that the resident was visibly upset with his emotions escalating. Staff A stated that she deescalated the situation, taking the resident for a walk around the unit until he was calmed down and able to return to his meal. Staff A stated that she reported the incident to Staff F, Executive Director (ED). Staff A stated that she witnessed Staff B working with residents the next day after she had made her report to Staff E, Resident Care Manager South (RCMS). Staff A stated that on multiple occasions, she had witnessed Staff B taunting Resident 2 (R2). Staff A stated that on one occurrence she heard loud voices coming from R2's room, she entered the room to investigate what was happening and could tell R2 was angry with Staff B. R2 was yelling at Staff B stating that Staff B was a horrible person. Staff A stated that she witnessed Staff B yelling back at R2 that she (R2) was a horrible person. Staff A stated that she immediately reported the incident to Staff E, RCMS. Staff A stated that she had went to Staff E multiple times with concerns related to how Staff B and Staff C, Caregiver, were aggressive and abusive to the residents. Staff A stated that around October 5, 2023, she had gone to Staff F and reported her concerns about Staff B and Staff C abusing residents. Staff A stated that she had voiced her concerns for abuse related to the incident where Resident 3 (R3) was injured while care was being performed by Staff B and Staff C. Staff A stated that Staff F reported to her that there were no concerns for abuse since R2's story and the story of the caregivers matched. Staff A stated that she was told by Staff F that proof was needed of the caregivers abusing residents and that Staff A needed to report incidents immediately before any actions could take place.

Record review of R2's Face Sheet, undated, showed R2 admitted on [redacted]/2022 with a history of Dementia (a loss of cognitive function thinking, remembering, and reasoning) and Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

Record review of R3's Face Sheet, undated, showed R3 admitted on [redacted]/2020 with a history of Dementia, Chronic Pain (Persistent pain that lasts weeks to years), Anxiety disorder. R3 had a history of resisting care. R3 required staff assistance for all daily living needs.

Record review of Incident Report for R3, dated 10/04/2023, showed R3 sustained a fracture to his right femur while peri care was being provided by Staff B, Staff C, and Staff D. Staff C reported that R3 did not want peri care provided and had become combative with the care staff and that they continued to provide resident care despite this. Staff D reported that R3 was punching and kicking at Staff C and Staff D while they continued to perform the care so she restrained R3's hands so that he would not be able to punch them. Staff D reported that while she was restraining R3 he kicked out, they heard a loud pop sound and

R3 yelled out in pain. Staff D reported after she heard the pop sound, she released R3's hands and went and notified Staff G of the incident.

In an interview on 10/18/2023 at 2:29pm, Staff E stated that it had been reported to her by Staff A that Staff B and Staff C were taunting residents. Staff E stated that she had reported the allegation to Staff F. Staff E stated that Staff A had also voiced concern to her that Staff B and Staff C had been too rough with their care to residents. Staff E stated that when she had asked Staff A to elaborate and provide examples Staff A was unable to do so. Staff E stated that she was unaware of a formal internal investigation completed related to the allegations of Staff B and Staff C being too rough with the residents. Staff E stated that on 10/04/2023, she had taken statements from Staff B, Staff C, and Staff D related to the incident that happened on 10/04/2023 where R3 sustained injuries while care was being provided to him by Staff B, Staff C, and Staff D. Staff E stated she did not interview R3 after the incident on 10/04/2023 to rule out abuse, that Staff G, Licensed Practical Nurse (LPN), had interviewed him.

In an interview on 10/19/2023 at 3:16pm, Staff G, stated that on 10/04/2023 Staff B, Staff C, and Staff D entered her office stating that R3 had been injured while they were performing care. Staff G stated that Staff E took statements from all three caregivers. Staff G stated that she went to R3's room to assess his injuries. Staff G stated that she interviewed R3 while in his room and that Staff B, Staff C and Staff D were present in R3's room while she interviewed R3. Staff G stated that she did not ask any questions to rule out abuse or mistreatment because she was more concerned with his injuries since he was in severe pain.

In an interview on 10/19/2023 at 4:18pm, Staff F stated that Staff A had come to her with concerns of Staff B and Staff C being too "rough" with the residents. Staff F stated that when she asked Staff A for examples or details of how Staff B and Staff C were being too rough all Staff A would say is "they are too rough". Staff F stated she had told Staff A that without details there was nothing she could do about the concerns of abuse. Staff F stated multiple times that the staff do not bring concerns up to her but will talk to other people about their concerns when they come into the building such as state investigators. Staff F stated that if the staff would bring concerns or report situations immediately then she would be able to do something about it. Staff F stated that she needed proof before she could do something about a suspicion or allegation of abuse. Staff F stated in the incident with R3, she did not feel that the staff members giving care at the time meant to harm. Staff F stated that she had a conversation with Staff B, Staff C and Staff D and had concluded that R3's injury had been caused by how rough their care was due to them forcing him to be cleaned up due to the feces all over him despite his refusal. Staff F stated that Staff B, Staff C and Staff D were interviewed, and that R3 had also been interviewed to rule out abuse. Staff F stated that R3 had been interviewed alone by Staff G.

This was a recurring deficiency for 388-78A-2600 (1)(a), previously cited on 04/11/2023.

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, GARDEN COURTE ALZHEIMER COMMUNITY 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-2450 Staff.

(2) The assisted living facility must:

(b) Verify staff persons' work references prior to hiring;

(3) The assisted living facility must:

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471 ; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to verify and maintain reference check documentation for 2 of 2 staff members (Staff B and Staff C) in each of their personnel files. This failure placed 80 of 80 residents at risk of receiving care from unqualified staff members.

Findings included…

“RCW 18.20.125 Inspections—Enforcement remedies—Screening—Limitations on unsupervised access to vulnerable adults…(3)(a)…Employees may be provisionally hired pending the results of the background check if they have been given three positive references…”

Record review of Staff B’s, caregiver, personnel file on 10/19/2023, showed Staff B had been hired on 11/19/2019. Three references were provided on Staff B’s application for employment. One reference check form was partially completed in Staff B’s personnel file, dated 11/19/2019.

Record review of Staff C's, caregiver, personnel file on 10/19/2023, showed Staff C was hired on 08/03/2022. One of three requested references had been provided on Staff C's application for employment. No reference check form was found in Staff C's personnel file.

In an interview with Staff H, Human Resources (HR), on 10/19/2023 at 4:05pm, Staff C stated that if any reference checks had been completed, they would have been in the employee's personnel file. Staff H stated that she had been employed with the company in her role as HR since January 2023. Staff H stated that she was responsible for employee files and keeping them updated with required documentations. Staff H stated that since starting as HR she does not complete reference checks. Staff H stated that she had not been taught to complete reference checks prior to hire of potential new employees. Staff H stated that the one incomplete reference check that was found in Staff B's employee file was completed prior to Staff H being employed as HR.

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, GARDEN COURTE ALZHEIMER COMMUNITY 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-2660 Resident rights. The assisted living facility must:

(7) Not allow any staff person to abuse or neglect any resident.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(3) Not use restraints on any resident;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to ensure staff had not abused or restrained residents for 3 of 3 residents (Resident 1, Resident 2, and Resident 3) reviewed. This failure contributed to Resident 3 being restrained, injured, and hospitalized, placed Resident 1 and 2 at risk of psychosocial harm, and placed all 80 of 80 residents at risk of abuse.

Findings included…

WAC 388-78A-2020 “Definitions... "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult… "Mental abuse" means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing... "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or... ”Physical restraint" means the application of physical force without use of any device for the purpose of restraining the free movement of a vulnerable adult's body..."

Review of the facility policy, titled, "Restraints and Enablers", undated, showed, "The use of restraints will not be used on any resident."

Record review of the facility’s Resident Incident/Accident log, dated 07/01/2023 through 10/18/2023, showed no incidents of staff to resident altercations.

In an interview on 10/18/2023 at 11:33am, Staff A, Caregiver, stated that she witnessed Staff B, Caregiver, taunting and yelling at Resident 1 (R1) to hit her. Staff A stated that the R1 was visibly upset with his emotions escalating. Staff A stated that she deescalated the situation, taking the resident for a walk around the unit until he was calmed down and able to return to his meal. Staff A stated that she reported the incident to Staff F, Executive Director (ED). Staff A stated that she witnessed Staff B working with residents the next day after she had made her report to Staff E. Staff A stated that she had witnessed Staff B taunting Resident 2 (R2) on multiple occasions. Staff A stated that on one occurrence she heard loud voices coming from R2’s room, she entered the room to investigate what was happening and could tell R2 was angry with Staff B. R2 was yelling at Staff B stating that Staff B was a horrible person. Staff A stated that she witnessed Staff B yelling back at R2 that R2 was a horrible person. Staff A stated that she immediately reported the incident to Staff E, Resident Care Manager South (RCMS). Staff A stated that she had went to Staff E multiple times with concerns related to how Staff B and Staff C, Caregiver, were aggressive and abusive to the residents. Staff A stated that around October 5, 2023, she had gone to Staff F and reported her concerns about Staff B and Staff C abusing residents. Staff A stated that she had voiced her concerns for abuse related to the incident where Resident 3 (R3) was injured while care was being performed by Staff B and Staff C. Staff A stated that Staff F reported to her that there were no concerns for abuse since R3’s story and the story of the caregivers matched. Staff A stated that she was told by Staff F that proof was needed of the caregivers abusing residents and that Staff A needed to report incidents immediately before any actions could take place.

Record review of R1’s Face Sheet, undated, showed R1 admitted to the facility on [redacted]/2021 with a history of Dementia (a loss of cognitive function thinking, remembering, and reasoning) and increased confusion.

Record review of R1's Service Plan, dated 07/01/2023, showed R1 was hard of hearing and required glasses to see adequately. R1 required one person assist for bathing. R1 suffered confusion and required reorientation to person and place. R1 required one person assist for dressing and grooming. R1 had clear speech and was able to make his needs known.

Record review of R2's Face Sheet, undated, showed R2 admitted on [redacted]/2022 with a history of Dementia and Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

Record review R2's Service Plan, dated 04/05/2023, showed R2 required one person assist for mobility in a wheelchair. R2 was able to speak and understand English. R2 was able to communicate clearly and make her needs known. R2 suffered mild confusion requiring frequent reorientation. R2 required one person assist for dressing and grooming. R2 suffered anxiety and would become very anxious with behaviors.

Record review of R3's Face Sheet, undated, showed R3 admitted on [redacted]/2020 with a history of Dementia, Chronic Pain (Persistent pain that lasts weeks to years), and Anxiety Disorder.

Record review of R3's Service Plan, dated 09/27/2023, showed R3 had a history of skin tears due to thinning skin. R3 had a history of a [redacted]. R3 required one person assist with bathing. R3 was able to understand English, able to follow simple directions, able to communicate clearly and be understood. R3 was orientated to self and location but suffered moderate short-term memory loss. R3 requited one person assist for dressing and grooming. R3 had a history of having bowel movements while in bed and then putting his hands in the feces. R3 had a history of becoming combative and resistive to care. R3 suffered chronic pain due to his [redacted].

Record review of Incident Report for R3, dated 10/04/2023, showed R3 sustained a fracture to his right femur while peri care was being provided by Staff B, Staff C, and Staff D. Staff C reported that R3 did not want peri care provided and had become combative with the care staff and that they continued to provide resident care despite R3's refusal. Staff D reported that R3 was punching and kicking at Staff C and Staff D while they continued to perform the care so she restrained R3's hands so that he would not be able to punch them. Staff D reported that while she was restraining R3, he kicked out, they heard a loud pop sound and R3 yelled out in pain. Staff D reported after she heard the "pop" sound she released R3's hands and went and notified Staff G of the incident. The incident report showed the resident was sent to the emergency department and had surgery on 10/05/2023.

In an interview on 10/18/2023 at 2:29pm, Staff E, RCMS, stated that it had been reported to her by Staff A that Staff B and Staff C were taunting residents. Staff E stated that she had reported the allegation to Staff F. Staff E stated that Staff A had previously voiced concerns

to her that Staff B and Staff C had been too rough with their care to residents. Staff E stated that when she had asked Staff A to elaborate and provide examples Staff A was unable to do so. Staff E stated that she was unaware of a formal internal investigation completed related to the allegations of Staff B and Staff C being too rough with the residents. Staff E stated that on 10/04/2023, she had taken statements from Staff B, Staff C, and Staff D related to the incident that happened on 10/04/2023 where R3 sustained injuries while care was being provided to him by Staff B, Staff C, and Staff D. Staff E stated she did not interview R3 after the incident on 10/04/2023 to rule out abuse, but that Staff G, Licensed Practical Nurse (LPN), had interviewed him.

In an interview on 10/19/2023 at 3:16pm, Staff G stated that on 10/04/2023 Staff B, Staff C, and Staff D entered her office stating that R3 had been injured while they were performing care. Staff G stated that Staff E took statements from all three caregivers. Staff G stated that she went to R3's room to assess his injuries. Staff G stated that she interviewed R3 while in his room and that Staff B, Staff C and Staff D were present in R3's room while she interviewed R3. Staff G stated that she did not ask any questions to rule out abuse or mistreatment because she was more concerned with his injuries since he was in severe pain.

In an interview on 10/19/2023 at 4:18pm, Staff F, ED, stated that Staff A had come to her with concerns of Staff B and Staff C being too "rough" with the residents. Staff F stated that when she asked Staff A for examples or details of how Staff B and Staff C were being too rough all Staff A would say is "they are too rough". Staff F stated she had told Staff A that without details there was nothing she could do about the concerns of abuse. Staff F stated multiple times that the staff do not bring concerns up to her but will talk to other people about their concerns when they come into the building such as state investigators. Staff F stated that if the staff would bring concerns or report situations immediately then she would be able to do something about it. Staff F stated that she needed proof before she could do something about a suspicion or allegation of abuse. Staff F stated in the incident with R3, she did not feel that the staff members giving care at the time meant to harm. Staff F stated that she had a conversation with Staff B, Staff C and Staff D and had concluded that R3's injury had been caused by how rough their care was due to them forcing him to be cleaned up due to the feces all over him despite his refusal. Staff F stated that Staff B, Staff C and Staff D were interviewed, and that R3 had also been interviewed to rule out abuse. Staff F stated that R3 had been interviewed alone by Staff G.

This was a recurring deficiency previously cited on 10/29/2021 for 388-78A-2660 (7).

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, GARDEN COURTE ALZHEIMER COMMUNITY 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-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090 (7).

This requirement was not met as evidenced by:

Based on interview and record review failed to ensure specialized dementia training for 2 of 3 staff (Staff A and Staff B). This failure resulted in Resident 1 (R1) sustaining a fractured femur and placed all 80 of 80 residents at risk of harm due to receiving care from untrained staff.

Findings included…

WAC 388-112A-0495 “What are the specialty training and supervision requirements for long-term care workers in adult family homes, assisted living facilities, and enhanced services facilities?... Assisted living facilities.(4) If an assisted living facility serves one or more residents with special needs, the assisted living facility must ensure that a long-term care worker employed by the facility demonstrates completion of, or completes and demonstrates competency in specialty training within one hundred twenty days of hire. However, if specialty training is not integrated with basic training, the specialty training must be completed within ninety days of completion of basic training. (5) Until a long-term care worker completes the specialty training and demonstrates competency as required under subsection (4) of this section, the home must not allow the long-term care worker to provide personal care to a resident with special needs without direct supervision, unless indirect supervision is allowed under subsection (6) of this section. (6) The long-term care worker may provide personal care with indirect supervision if one or more of the following requirements are met:
(a) The long-term care worker is a nursing assistant certified (NA-C) under chapter 18.88A RCW;
(b) The long-term care worker is a certified home care aide (HCA) under chapter 18.88B RCW;
(c) The long-term care worker is a licensed practical nurse (LPN) under chapter 18.79 RCW;
(d) The long-term care worker is a registered nurse (RN) under chapter 18.79 RCW; or
(e) The long-term care worker is exempt from the seventy-hour basic training under WAC 388-112A-0090….”

Record review of Staff D, Caregiver, employee file showed Staff D was hired on 03/14/2023. Review of Staff D’s employee file showed no certificate of completion of state

approved Dementia Specialty Training.

Record review of Staff C, Caregiver, employee file showed Staff C was hired on 08/03/2022. Review of Staff C's employee file showed no certificate of completion of state approved Dementia Specialty Training.

Record review of Washington State Department of Health Provider Credential Search, dated 11/28/2023, showed no records were found for Staff D.

Record review of Washington State Department of Health Provider Credential Search, dated 11/28/2023, showed Nursing Assistant Registration first issued to Staff C on 08-17-2022, status active.

Record review of an email received by the Department on 11/28/2023 at 9:11am, showed Staff F, Executive Director (ED), replied that Staff D and Staff C had not completed the DSHS approved Dementia Specialty Training prior to their termination on 11-02-2023.

Record review of R3's Face Sheet, undated, showed R3 admitted on [redacted]/2020 with a history of Dementia, Chronic Pain (Persistent pain that lasts weeks to years), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

Record review of R3's Service Plan, dated 09/27/2023, showed R3 had a history of skin tears due to thinning skin. R3 had a history of a [redacted]. R3 required one person assist with bathing. R3 was able to understand English, able to follow simple directions, able to communicate clearly and be understood. R3 was orientated to self and location but suffered moderate short-term memory loss. R3 requited one person assist for dressing and grooming. R3 had a history of having bowel movements while in bed and then putting his hands in the feces. R3 had a history of becoming combative and resistive to care. R3 suffered chronic pain due to his [redacted].

Record review of an Incident Report for R3, dated 10/04/2023, showed R3 sustained a fracture to his right femur while peri care was being provided by Staff D and Staff C. Staff C reported that R3 did not want peri care provided and had become combative with them. Staff C stated they continued to provide resident care despite R3's refusal. Staff D reported that R3 was punching and kicking at her and Staff C while they continued to perform the care so she restrained R3's hands so that he would not be able to punch them. Staff D reported that while she was restraining R3 he kicked out, they heard a loud pop sound and R3 yelled out in pain. Staff D reported after she heard the pop sound, she released R3's hands and went and notified the Licensed Practical Nurse on duty.

In an interview on 10/19/2023 at 4:18pm, Staff F, ED, stated that she had a verbal conversation with Staff D and Staff C about sometimes what they may believe is joking with a resident may in fact be taunting a resident or may be upsetting a resident and that it was

not acceptable. In the incident with R3, Staff F stated that she did not feel that the staff members giving care at the time meant to harm. Staff F stated that she had a conversation with Staff D and Staff C and had concluded that R3's injury had been caused by how rough their care was due to them forcing him to be cleaned up due to the feces all over him despite his refusal.

In an interview on 10/19/2023 at 4:05pm, Staff H, Human Resource (HR), stated that the facility in the past had a certified person to teach the DSHS approved special focus classes in house. That staff member no longer worked for the facility. Staff H stated that since she has been in HR they have not hosted any DSHS approved training in house or had the employees attend outsourced classes. Staff H stated that she is not certified to teach any of the DSHS approved training classes.

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, GARDEN COURTE ALZHEIMER COMMUNITY 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