STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Kenneth Russell Roughton
Patit Creek Adult Residential Care
PO BOX 49
DAYTON, WA 99328

RE: Patit Creek Adult Residential Care License # 1180

Dear Administrator:

This letter addresses Compliance Determination(s) 27279 (Completion Date 07/27/2023) and 25781 (Completion Date 06/23/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/27/2023 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-2630-1-a

The Department staff who did the on-site verification:
Sylvia Shauvin, Complaint Investigator

If you have any questions, please contact me at (509)323-7315.

Sincerely,

JSalquist
Jessica Salquist, Field Manager
Region 1, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Patit Creek Adult Residential Care
Provider Type: Assisted Living Facility
License/Cert.#: 1180
Intake ID: 83545
Compliance Determination #: 25781
Region/Unit #: RCS Region 1 / Unit B
Investigator: Sylvia Shauvin
Investigation Date(s): 06/23/2023 through 06/23/2023
Complainant Contact Date(s): 06/13/2023, 06/23/2023

Allegation(s):
1 - Theft of resident's valuables - phone, laptop, and watch.

Investigation Methods:

Sample:	Total residents: 29 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents' well-being Residents' access to safe storage Staff's care and treatment of residents Staff's response to residents' concerns
Interviews:	Eight residents Facility caregiver Administrator Home and Community Services Case Resource Manager (HCS - CRM)
Record Reviews:	Sample residents' Face Sheets, assessments, care plans Facility's Incident Notes Facility's Policy and Procedures - Suspected Abuse Admission Agreement Disclosure of Services Staffing schedule - June 2023

Investigation Summary:
1 - As observed, locks had been installed on residents' apartment doors. Two randomly interviewed residents stated the facility recently installed the locks because of theft of residents' belongings. Per interviews with HCS - CRM, facility caregiver, and Administrator; and Incident Notes, a resident stole and sold another resident's Apple watch for $100.00. Per interviews with the caregiver and Administrator, facility failed to report the theft to the department abuse/neglect hot line. The failed facility practice was documented in 06/23/2023 Statement of Deficiencies under Washington Administrative Code 388-78a-2630(1) Reporting abuse and neglect.

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 #: 1180	Compliance Determination # 25781
Plan of Correction	Patit Creek Adult Residential Care	Completion Date
Page 1 of 3	Licensee: Kenneth Russell Roughton	06/23/2023

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 06/23/2023, 06/23/2023 and 06/23/2023 at:

Patit Creek Adult Residential Care
423 W Main St
Dayton, WA 99328

This document references the following complaint number(s): 84997, 83545

The following sample was selected for review during the unannounced on-site visit: 3 of 28 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Sylvia Shauvin, Complaint Investigator

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JUL 03 2023
DSHS ALTSA RCS
SPOKANE VALLEY WA

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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 — 06/28/2023 (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.

Mary Roughton
Administrator (or Representative)

7.3.23
Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to immediately report an allegation of financial exploitation to the Complaint Resolution Unit for 1 of 3 residents (Resident 1). This failed reporting practice precluded the department from having immediate knowledge to conduct an investigation and placed the resident at risk of financial exploitation.

Findings included...

Review of orientation content for Staff A, Administrator, and Staff B, Caregiver, dated 12/20/2011 and 08/30/2018, respectively, showed they received orientation to the facility's policy regarding reporting abuse and neglect.

The facility's Policy and Procedures for "Suspected Abuse", dated 2/18/2023, showed staff should report exploitation of vulnerable adults to the department abuse-neglect hot line. Per this document, exploitation included the illegal or improper use of a vulnerable adult or vulnerable adult's resources for another person's profit or advantage.

Review of a facility Incident Note, dated 05/23/2023, showed that an individual that did not work or live in the facility had purchased a watch that belonged to Resident 1. The Incident Note showed that Resident 2 had sold the watch to the individual. Further review of the Incident Note showed that Resident 1 did not give the watch to Resident 2.

In an interview on 08/23/2023 at 12:00 PM, Staff B stated an individual informed the facility that Resident 2 had sold Resident 1's watch to them. Staff B stated Resident 1's watch had been stolen out of Resident 1's car that "was broken into". Staff B further stated that they were uncertain of reporting requirements.

Statement of Deficiencies	License #: 1160	Compliance Determination # 25781
Plan of Correction	Patit Creek Adult Residential Care	Completion Date
Page 3 of 3	Licensee: Kenneth Russell Roughton	06/23/2023

In an interview on 06/23/2023 at 12:30 PM, Staff A stated several weeks prior, an individual came to the facility because they had a watch that belonged to Resident 1. Staff A stated the individual told them that they had purchased the watch from Resident 2. When asked by the department investigator what was done in response, Staff A stated they did not make a report to the Complaint Resolution unit because they didn't think they had to do so.

In an interview on 06/23/2023 at 2:55 PM, Collateral Contact 1 stated in late May 2023, Staff A informed them that Resident 2 stole items including, a watch, an iPad, and an iPhone, belonging to Resident 1. The Collateral Contact further stated they advised Staff A to make a report to the department abuse-neglect hot line.

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, Patit Creek Adult Residential Care is or will be in compliance with this law and / or regulation on (Date) 7/15/23

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

Kenneth Roughton — Administrator (or Representative)

7.3.23 — Date