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

PUBLIC HOSPITAL #3 OF GRANT COUNTY
Garden Oasis
200 NAT WASHINGTON WAY
Ephrata, WA 98823

RE: Garden Oasis License # 1199

Dear Administrator:

This letter addresses Compliance Determination(s) 48984 (Completion Date 10/21/2024) and 45552 (Completion Date 08/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/21/2024 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-2140-1-a-iii, WAC 388-78A-2140-1-c, WAC 388-78A-2140-1-d, WAC 388-78A-2660-1, RCW 70.129.030.4, WAC 388-78A-2466-1-a, WAC 388-78A-2474-2-a, WAC 388-78A-2474-3, WAC 388-112A-0200-1

The Department staff who did the on-site verification:
Robin Rainville, Assisted Living Facility Licensor
Elizabeth Hall, AFH/ALF Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Field Manager
Region 1, Unit G
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

Statement of Deficiencies	License #: 1199	Compliance Determination # 45552
Plan of Correction	Garden Oasis	Completion Date
Page 1 of 9	Licensee: PUBLIC HOSPITAL #3 OF GRANT	08/22/2024

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 the unannounced on-site full inspection on 08/20/2024, 08/21/2024 and 08/22/2024 of:
Garden Oasis
200 NAT WASHINGTON WAY
Ephrata, WA 98823

The following sample was selected for review during the unannounced on-site visit: 5 of 27 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Elizabeth Hall, AFH/ALF Licensor
Elaine Lopez, Licensor
Robin Rainville, 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

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 — 08/28/2024 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.

Liebrecht RN NHA
Administrator (or Representative)

9/6/24
Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(1) The care and services necessary to meet the resident's needs, including:

(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following:

(iii) On-going assessments of the resident;

(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;

(d) The plan to provide necessary health support services, if provided by the assisted living facility;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to develop and document in the resident's record, the plan to meet the residents' assessed needs that could have a risk to their health and safety, for 3 of 5 residents (Residents 1, 4, and 5). This failure placed residents at risk of harm and unmet care needs.

Findings included...

Resident 5

Observation on 08/22/2024 at 9:28 AM showed that Resident 5 had a white gauze roll bandage over the top of their head, with a padded dressing placed over the right temple area.

In an interview on 08/22/2024 at 9:48 AM, Resident 5 stated that they had a lesion removed from the right side of their face, the day before. Resident 5 stated the previous night, the bandage had fallen down over their eyes in their sleep and they had to call staff to help them readjust the bandage. Resident 5 further stated that they received therapy services in the ALF. Resident 5 stated that they usually walked to the therapy, but sometimes the staff pushed them in a wheelchair.

Review of Resident 5's facility assessment, dated 03/22/2024, showed that the resident

had a history of a stroke (an interruption to the blood flow in the brain causing damage), and had multiple lesions on their face, back and arms which had required treatment from a doctor.

Review of Resident 5's physician's order, dated 03/20/2024, showed that the resident had orders for physical therapy.

Review of Resident 5's physician's office visit note, dated 08/16/2024, showed that the resident had a history of skin lesions on their face, back, chest and arms. The note showed that Resident 5 had a current lesion on their face which had become painful and was draining.

Review of Resident 5's physician's progress note, dated 08/21/2024, showed that the resident had a skin lesion removed from the right side of their face. The note showed that five stitches had been placed to close Resident 5's surgical wound.

Review of Resident 5's physician's order, dated 08/21/2024, showed that the resident was to have dressing changes two times a day for the wound on the right side of Resident 5's head.

Review of Resident 5's negotiated service agreement (NSA), dated 08/09/2024, showed that there was no documentation on the NSA that provided information and direction to the staff on how to care for the resident's current and chronic skin condition. The NSA did not include information about Resident 5's diagnosis of [redacted] or what the staff needed to know regarding monitoring and interventions following [redacted]. Further review showed the NSA did not show Resident 5's need for physical therapy or who provided the therapy services.

In an interview on 08/21/2024 at 10:44 AM, Staff K, Certified Nursing Assistant, stated that changes in a resident's condition would be documented in the ALF's communication binder for all resident issues. Staff K stated that Resident 5's skin and wound information should be on their care plan.

In an interview on 08/22/2024 at 10:20 AM, Staff J, Registered Nurse (RN), stated that communication to the care staff regarding Resident 5's wound care needs would be done verbally at shift change or in the facility communication log. Staff J stated that the wound information for Resident 5 was not documented on the communication log.

Resident 4

Review of Resident 4's facility assessment, dated 06/13/2024, showed that the resident had a diagnosis of [redacted]. Resident

4's assessment showed that the resident had, "several cyst type lesions on [their] left side which [Resident 4] picks at, so they are constantly oozing blood and scabbed." The assessment further showed that Resident 4 required assistance with showers, was resistant to showering and was, "very unkempt."

Review of Resident 4's NSA, dated 06/14/2024, showed that it did not include documentation of the resident's significant diagnosis of [redacted], what to watch for should they experience a flare up of the condition, or any special handling instructions for the resident's personal items should they become soiled with bodily fluid.

In an interview on 08/22/2024 at 10:21 AM, Staff J stated the staff were to use, "just universal precautions" when working with residents. Staff J acknowledged that Resident 4's significant diagnosis was not on their NSA.

Resident 1

Review of Resident 1's facility assessment, dated 02/06/2024, showed that the resident had diagnoses that included [redacted], and [redacted]. The assessment showed that Resident 1 had a cardiac pacemaker (a surgically implanted device that regulated the heartbeat) and that the resident would call staff when the pacemaker, "fires, which frightens the resident."

Review of Resident 1's NSA, dated 06/27/2024, showed no documentation of the resident's pacemaker. The NSA did not show how the device was monitored and who to contact about the device if needed.

In an interview on 08/21/2024 at 12:35 PM, Staff I, RN/Resident Care Manager, acknowledged that Resident 1's pacemaker information was not on the NSA.

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 Oasis is or will be in compliance with this law and / or regulation on (Date) 10/1/24 .

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

Administrator (or Representative) — Date: 9/6/24

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

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

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to inform each resident at least every twenty-four months in writing of the service items, charges, activities available in the facility, and the rules of the facility's operation, when residents lived in the facility for more than twenty-four months, for 2 of 2 residents (Resident 4 and 5). This failure prevented residents from making informed decisions regarding living choices at the ALF.

Findings included...

In an interview on 08/21/2024 at 4:21 PM, Staff A, Registered Nurse/Administrator, stated that Staff H, Director of Social Services, was responsible for the twenty-four-month review of the ALF's service items, activities available in the facility, and the rules of the facility's operation found in the rental agreements, with residents.

Review of Resident 4's record showed an admission date of [redacted]/2020. The record showed the most current rental agreement was signed [redacted]/2020. The record did not show a twenty-four-month review of Resident 4's rental agreement was completed that contained service items, activities available in the facility, and the rules of the facility's operation.

Review of Resident 5's record showed an admission date of [redacted]/2022. The record showed the most current rental agreement was signed 10/24/2016. The record did not show a twenty-four-month review of Resident 5's rental agreement was completed that contained service items, activities available in the facility, and the rules of the facility's operation.

In an interview on 08/22/2024 at 10:25 AM, Staff H stated that the facility did not have a system in place to track twenty-four-month review of the resident rental agreements. Staff H stated the facility only informed residents of service items, activities available in the facility, and the rules of the facility's operation upon initial admission.

In an interview on 08/22/2024 at 10:36 AM, Staff H stated that they did not know the reason for the discrepancy between Resident 5's recorded admission date and the rental agreement date, and that Resident 5 may have been out of the facility for an extended period.

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: 9/6/24

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that a new DSHS background authorization form was submitted every two years for 2 of

3 staff (Staff E and F). This failure placed the residents at risk of being cared for by disqualified staff.

Findings included...

Review of the personnel file for Staff E, Certified Nursing Assistant, showed a hire date of 06/21/2021. Staff E's file showed that their most recent background check was completed on 07/24/2023. Staff E's file showed a previous background check was completed on 07/17/2021, which was two years and seven days prior.

Review of the personnel file for Staff F, Activities Assistant, showed a hire date of 02/15/2022. Staff F's file showed that their most recent background check was completed on 08/06/2024. Staff E's file showed a previous background check was completed on 06/23/2022, which was two years and 41 days prior.

In an interview on 08/21/2024 at 2:37 PM, Staff G, Human Resources Director, stated that the facility only recently found that Staff F's two-year background check had been missed, and it had been competed at that time.

In an interview on 08/22/2024 at 8:54 AM, Staff A, Registered Nurse/Administrator, stated that they did not know why Staff E's two-year background check had been completed late.

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 Oasis is or will be in compliance with this law and / or regulation on (Date) 9/6/24 .

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

Administrator (or Representative) — Date: 9/6/24

WAC 388-112A-0200 What is orientation training, who should complete it, and when should it be completed? There are two types of orientation training: Facility orientation training and long-term care worker orientation training.

(1) Facility orientation. Individuals who are exempt from certification as described in RCW 18.88B.041 and volunteers are required to complete facility orientation training before having routine interaction with residents. This training provides basic introductory information appropriate to the residential care setting and population served. The department does not approve this specific orientation program, materials, or trainers. No test is required for this orientation.

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure that staff received facility orientation prior to routine interaction with residents, for 3 of 3 staff (Staff B, C and D). This failure placed residents at risk of being cared for by staff who were unfamiliar with the facility and their processes.

Findings included...

Review of the personnel file for Staff B, Certified Nursing Assistant (CNA), showed that they were hired on 06/25/2024. Staff B's file did not show that they had received facility orientation.

Review of the personnel file for Staff C, CNA, showed that they were hired on 10/31/2023. Staff C's file showed that they had completed facility orientation on 01/04/2024, 66 days after hire.

Review of the file for Staff D, CNA, showed that they were hired on 06/27/2023. Staff D's file did not show that they had received facility orientation.

In an interview on 08/21/2024 at 1:57 PM, Staff G, Human Resources Director, confirmed that Staff B, C, and D, had been working with residents prior to completion of facility orientation. Staff G further stated that the facility policy was for facility orientation to be completed by the end of a staff member's 90-day review period.

In an interview on 08/22/2024 at 11:54 AM, Staff A, Registered Nurse/Administrator, stated that the facility would have to change their facility orientation form to meet the requirement.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1199	Compliance Determination # 45552
Plan of Correction	Garden Oasis	Completion Date
Page 9 of 9	Licensee: PUBLIC HOSPITAL #3 OF GRANT	08/22/2024

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 Oasis is or will be in compliance with this law and / or regulation on (Date) 10/1/24 .

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

Liebeldt RN NDM — Administrator (or Representative)

9/6/24 — Date

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

PUBLIC HOSPITAL #3 OF GRANT COUNTY
Garden Oasis
200 NAT WASHINGTON WAY
Ephrata, WA 98823

RE: Garden Oasis # 1199

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 08/22/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Stephanie Jenks, Field Manager
Residential Care Services
Region 1, Unit G
1200 Alder Street

Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

The Assisted Living Facility failed to ensure a staff member was screened for tuberculosis (TB) within three days of hire. The facility ensured that all new staff would be screened for TB within three days of hire.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:
• Please contact me at (509)993-7821.

Sincerely,

Stephanie Jones

Stephanie Jenks, Field Manager
Region 1, Unit G
Residential Care Services

Enclosure