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

WASHINGTON ODD FELLOWS HOME

WASHINGTON ODD FELLOWS HOME
534 Boyer Ave
Walla Walla, WA 99362

RE: WASHINGTON ODD FELLOWS HOME License # 125

Dear Administrator:

This letter addresses Compliance Determination(s) 54044 (Completion Date 01/30/2025) and 49887 (Completion Date 12/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/30/2025 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-2660-1, RCW 70.129.110.3.a, RCW 70.129.110.6, RCW 70.129.110.7

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: WASHINGTON ODD FELLOWS HOME
License/Cert.#: 125
Compliance Determination #: 49887
Investigator: Laura Williams-Davis
Provider Type: Assisted Living Facility
Intake ID: 153501
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s): 11/05/2024, 11/25/2024

Allegation(s):
The facility discharged a resident without proper reason and discharged them to an unsafe location.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Staff to resident interactions Resident to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Collateral Contacts
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
The facility alleged drug use at the facility despite no confirmation. Record reviews and interviews showed the facility assessed the Identified Resident required facility assistance with their prescribed medications. The resident's care plan directed staff oversight of medication management including ordering medications, administrating the medications as prescribed and ensuring any changes made by their primary care physician were followed. Interviews, record reviews showed the facility did not ensure the Identified Resident was discharged to a safe destination able to meet their needs. Please see the Statement of Deficiency dated 11/25/2024 for citations related to Washington Administrative Code 388-78a-2660 (1) and Revised Code of Washington 70.129.110 (3)(a)(b)(c)(6)(7) related to resident rights and discharge.

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: WASHINGTON ODD FELLOWS HOME
License/Cert.#: 125
Compliance Determination #: 49887
Investigator: Laura Williams-Davis
Investigation Date(s): 11/06/2024 through 12/17/2024
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 152987
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
The facility discharged the Identified Resident to a homeless shelter.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Social services staff
Record Reviews:	Medical records Hospital records Incident investigation Facility policies

Investigation Summary:
Interviews and record reviews showed the facility issued an immediate discharge to a homeless shelter unable to manage and administer physician prescribed medications. Failed practice identified. Please see the Statement of Deficiency dated 11/25/2024 for citations related to Washington Administrative Code 388-78a-2660 (1) and Revised Code of Washington 70.129.110 (3)(a)(b)(c)(6)(7) related to resident rights and discharge.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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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 Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 11/06/2024 and 11/06/2024 of:

WASHINGTON ODD FELLOWS HOME
534 Boyer Ave
Walla Walla, WA 99362

This document references the following complaint number(s): 152229, 153501, 152987

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator
Krista Connelly, Community Nurse Consultant
Laura Williams-Davis, ALF Field Manager
Jessica Salquist, Regional Administrator

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.

J Salquist
Residential Care Services

12/30/2024
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) 01-07-2025 Date

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility. [1997 c 392 205; 1994 c 214 12.] NOTES: Short title -- Findings -- Construction -- Conflict with federal requirements -- Part headings and captions not law -- 1997 c 392: See notes following RCW 74.39A.009 .

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, observation and record review, the Assisted Living Facility (ALF) failed to ensure a safe and orderly discharge 1 of 3 residents (Resident 1) who lived at the facility. This failure resulted in the resident being discharged to a shelter that was unable to meet any medical or nursing services. This contributed to the resident leaving the shelter with no known location.

Findings included...

Record review of Resident 1's ALF Negotiated Service agreement (NSA) dated 08/27/2024 showed that Resident 1 was admitted to the facility for medication management. Resident 1 had a diagnosis of [redacted]. The Parkinson's disease caused Resident 1 to fall frequently due to poor balance. Resident 1 also had anxiousness about getting their Parkinson's medications on time every four hours and staff were to

provide one on one coping assistance until the medication's scheduled time.

Record review of the facility documentation titled Nursing Home Transfer or Discharge Notice dated [redacted]/2024 showed that Resident 1 was being given a thirty-day notice of discharge ([redacted]/2024) for supplying marijuana to another resident in the facility and for nonpayment of their participation fees since admission. The form showed that Resident 1 was being discharged to an assisted living facility of choice, not a specified facility.

Record review of the facility Incident Report dated [redacted]/2024 showed that Resident 1 had behavioral episodes during which the resident tore up their recliner and removed the heating unit from the wall. The report showed that the Resident 1 was going to be discharged to the shelter due to the damage to the room.

Record review of the Resident 1's progress notes showed the resident was transported to the shelter on [redacted]/2024 and the shelter was full. A note dated 10/28/2024 showed the resident was transported to the shelter with their belongings.

In an interview on 11/06/2024 at 11:20 AM, Staff A, Administrator stated that Resident 1 had destroyed their room and Staff B, Chief Executive Officer (CEO) recommended a discharge due to the property damage and for barricading themselves in their room. Staff A stated that Staff B directed them to discharge Resident 1 to the shelter as it was considered a safe discharge because they provide services there. Staff A stated that they were unsure if the shelter provided similar care levels to the facility.

In an interview on 11/20/2024 at 3:40 PM, Collateral Contact 2 (CC2), Shelter Staff, stated that Resident 1 was at the shelter after 10/28/2024 and was not appropriate to be stay there. CC2 stated that they were not told by the facility about the level of assistance that Resident 1 required. They stated that Resident 1 was unable to perform even basic Activities of Daily Living (ADL's) like ensuring their face and clothing were clean after meals, showering or doing laundry. CC2 stated that Resident 1 was incontinent and unable to clean themselves causing a dignity concern. CC2 stated that Resident 1 had multiple falls since being at the shelter possibly from their meds not being balanced. They stated that they are only able to store medications for people at the shelter but had to have outside assistance to get the medications for Resident 1. CC2 stated they asked the facility to take Resident 1 back due to the care needs and they told CC2 they were unable.

In an interview on 11/26/2024 at 2:45 PM, Collateral Contact 1(CC1) Community Paramedic, stated that Resident 1 was no longer at the shelter and had been presenting to the local emergency department for medical care multiple times in the past couple of days.

Plan/Attestation Statement

Statement of Deficiencies	License #: 125	Compliance Determination # 49887
Plan of Correction	WASHINGTON ODD FELLOWS HOME	Completion Date
Page 5 of 5	Licensee: WASHINGTON ODD FELLOWS HOME	12/17/2024

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, WASHINGTON ODD FELLOWS HOME is or will be in compliance with this law and / or regulation on (Date) 12-30-2024

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

Administrator (or Representative)

01-07-2025
Date

WAC 388-78A-2660

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

STEP ONE

How the facility will correct the deficiency for each numbered resident

If the resident has been discharged or no longer living at the facility, state this. If no residents were included in this citation, state this.

Resident 1 – resident is no longer living at the facility

STEP TWO

How the facility will protect other residents in similar situations

If there is any possibility that other residents may incur a similar situation, address how you will prevent that from occurring.

Clarification has been received regarding the proper procedure and requirements for discharging residents. Any 30-day notices that will be give will follow safe discharge procedures.

STEP THREE

Measures the facility will take or the systems it will change to ensure the problem does not recur

Often times citations for specific situations are more widespread than the citation indicates. What overall systemic changes will take place so that the problem doesn't happen again? This may be staff training, changing a policy/procedure, changing a staff member, discharging a resident...it's specific to the issue at hand.

1. A more in-depth screening process for potential residents has been put in place.
    a. Facility will use the Resident History Pre-Admission Questionnaire for all potential residents with a history of substance use.
2. When giving a 30-day discharge notice, a location will be designated on the discharge form to notify the resident where they will be discharging.
3. Prior to admission, during the screening process, facility will identify any alternative options for placement for residents who have a history of behaviors and/or substance use.

STEP FOUR

How the facility plans to monitor its ongoing performance to sustain compliance

It's not "fix it and forget it." Identify monitoring methods and include frequency.

1. Any 30-day notices given by the facility will be reviewed to ensure that each step identified above was taken as necessary. If any component is found to be missing following the issuance of a 30-day notice, an investigation will be conducted to determine what systems need to be put in place to ensure compliance with the outlined procedure.

2. Additional screening for potential residents, as listed in Step 3, are outlined in Admission of a Resident Policy.

STEP FIVE

Dates corrective action will be completed

Cannot be more than 45 days.

System has already been put in place.

STEP SIX

Title of the person responsible to ensure correction

Name the person who is responsible for this plan.

Alecksana Potter – Administrator of the facility