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

CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC
GUARDIAN ANGEL HOMES (THE COTTAGE)
245 VAN GIESEN ST
RICHLAND, WA 99352

RE: GUARDIAN ANGEL HOMES (THE COTTAGE) License # 1513

Dear Administrator:

This letter addresses Compliance Determination(s) 33422 (Completion Date 12/12/2023) and 29947 (Completion Date 10/10/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/12/2023 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-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-4

The Department staff who did the on-site verification:
Anna Cairns, ALF Long Term Care Surveyor
Jessica Clapp, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: GUARDIAN ANGEL HOMES (THE COTTAGE)
License/Cert.#: 1513
Compliance Determination #: 29947
Investigator: Melissa Milanez
Investigation Date(s): 09/22/2023 through 10/10/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 98453
Region/Unit #: RCS Region 1 / Unit G

Allegation(s):
Identified resident reported mental, physical and sexual abuse.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 7 Closed records sample size:
Observations:	Environment, cares, residents, resident rooms, staff availability and response to resident's needs, staff to resident interactions.
Interviews:	Residents, staff, and others associated with the facility.
Record Reviews:	Characteristic roster, Resident Records (Face sheet, Assessment, Care Plan, Progress Notes, Physician orders), facility policies, investigation reports, staff schedules, staff phone list, staff records.

Investigation Summary:
Observation, interview, and record review showed that the named resident reported to a caregiver that they had been sexually abused by a named staff member. The named resident showed that they did not feel safe and had concerns that the alleged perpetrator would be back to harm them. Interviews and record review showed that a thorough investigation was not completed, and resident were not kept safe during the investigation. Deficient practice identified, see the statement of deficiency for failing to thoroughly investigate, determine the circumstances of the event, and failed to protect all residents during the investigation WAC 388-78A-2371 dated 10/10/2023.

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 # 1513	Compliance Determination # 29947
Plan of Correction	GUARDIAN ANGEL HOMES (THE COTTAGE)	Completion Date
Page 1 of 4	Licensee: CAMP I RICHLAND REAL ESTATE HOLDING CO, LLC	10/10/2023

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 09/22/2023 and 09/23/2023 of:

GUARDIAN ANGEL HOMES (THE COTTAGE)
245 Van Giesen St
Richland, WA 99354

This document references the following complaint number(s): 98453

The following sample was selected for review during the unannounced on-site visit: 7 of 71 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Mianez, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1208 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

Gwin Kaercher
Residential Care Services

10/17/2023
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.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

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GUARDIAN ANGEL HOMES (THE COTTAGE)
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Richland, WA 99354

This document references the following complaint number(s): 98453

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The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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

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: 10/27/2023

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to thoroughly investigate, determine the circumstances of an allegation of abuse for 1 of 7 residents (Resident 1) and failed to protect Resident 1 and other residents who resided in the ALF during the investigation. These failures placed the residents at risk of abuse and at risk of receiving care from an alleged perpetrator.

Findings included...

Record review of the facility's policy titled, "Prevention of Abuse," dated as 2022, showed the Community has designated the Administrator as the person responsible for internally receiving the reports of resident abuse, including physical and sexual assault, neglect, abandonment, financial exploitation and to also promote the safety and well-being of their residents. If upon receiving a report of the above, an employee has been named as the person who may have committed the act, that employee will not be permitted to have any resident contact until the community completes the investigation and both the community and the Department of Social and Health Services are satisfied that the resident will be safe if the employee returns. The community has designated the Administrator as the person responsible for promptly initiating the investigation.

Interview on 09/22/2023 at 12:58 PM, Staff A, Administrator, stated that they received a phone call regarding an allegation Resident 1 made of sexual abuse on 09/15/2023. Staff A stated they did not have an investigation report put together for the sexual abuse allegation but did not think it had happened because the Resident 1 had made similar accusations in the past. Staff A also confirmed that they had not reported the incident to the Department.

Interview on 09/22/2023 at 1:05 PM, with Staff B, Health and Wellness Director, stated that

Administrator (or Representative) Date

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Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to thoroughly investigate, determine the circumstances of an allegation of abuse for 1 of 7 residents (Resident 1) and failed to protect Resident 1 and other residents who resided in the ALF during the investigation. These failures placed the residents at risk of abuse and at risk of receiving care from an alleged perpetrator.

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Interview on 09/22/2023 at 12:58 PM, Staff A, Administrator, stated that they received a phone call regarding an allegation Resident 1 made of sexual abuse on 09/15/2023. Staff A stated they did not have an investigation report put together for the sexual abuse allegation but did not think it had happened because the Resident 1 had made similar accusations in the past. Staff A also confirmed that they had not reported the incident to the Department.

Interview on 09/22/2023 at 1:05 PM, with Staff B, Health and Wellness Director, stated that

Resident 1 was alert and able to make their needs known. Additionally, Staff B stated that this was not the first time that Resident 1 had made these types of accusations but stated there was nothing to show in the Resident 1's records or history of similar allegations. Staff B stated that they had just become aware of bruising to Resident 1's breast and had not been previously aware of bruising. Because of this, Staff B had not yet completed a skin and body assessment of Resident 1. Staff B stated they only became aware of the bruising because a different investigative authority informed Staff A of the bruising on 09/21/2023.

Interview on 09/22/2023 at 1:54 PM with Staff C, Caregiver, stated that they had not been interviewed by Staff A or other administrative staff regarding the incident (allegation of abuse) on 09/15/2023. Staff C stated that Resident 1 had been telling them for two weeks that a tall man had been entering their room and touching their breast, but that they had not told anyone about the allegations because they were new to working with the resident and was not sure if they had Dementia (memory loss). Staff E also stated that prior to this incident Resident 1 spent most of their time in their room alone but had noticed a recent change in behavior. They stated that Resident 1 had stated they were scared to be alone because a tall man had touched their breasts. Staff C stated that now Resident 1 spent most of their time with other residents in the common area.

Interview and observation on 09/22/2023 at 2:07 PM, Resident 1, was observed sitting in the living room area with other residents, watching television. Resident 1 stated that there was a tall, skinny man that always wore a black cap that worked at the facility who grabbed their breasts and told them they would be back to rape them. Additionally, they stated that they had told a staff member about the incident the night it happened, but they did nothing about it. Resident 1 also stated that they had bruises on their breast. They also stated that they were afraid at night because they had saw the same man at their window.

Interview on 09/22/2023 at 2:24 PM with Staff D, Caregiver, stated that on 09/15/2023 they reported to Staff A abuse allegations that had been reported to them by Resident 1. Staff D stated that they had not been asked to write down their statement until 09/22/2023 as they arrived to work that evening shift and prior to speaking on this interview. Staff D stated that they reported to Staff A that Resident 1 had stated to them that on several occasions a tall, skinny man carrying a red jug, wearing a cap and all black had entered their room and touched their breast. Staff C also stated that Resident 1 stated that the unidentified man threatened them that they would return. Staff C stated they observed the bruises on Resident 1's breasts and had taken pictures for another investigative authority but did not report it to Staff A because it was the end of their shift.

Interview on 10/09/2023 at 3:46 PM Staff B, Caregiver/alleged perpetrator confirmed that they worked from 10:00 PM through 6:00 AM the night of 09/15/2023 (the day after the alleged incident). Staff B also confirmed that they entered Resident 1's place of residence after the alleged allegations unfolded to assist another caregiver providing care to another resident. Staff B stated that they did not feel comfortable re-entering the unit, but that they had been the only float person available that night and needed to assist another caregiver with a two-person resident brief change. Staff B confirmed that they were never told to not enter the house.

Resident 1 was alert and able to make their needs known. Additionally, Staff B stated that this was not the first time that Resident 1 had made these types of accusations but stated there was nothing to show in the Resident 1's records or history of similar allegations. Staff B stated that they had just become aware of bruising to Resident 1's breast and had not been previously aware of bruising. Because of this, Staff B had not yet completed a skin and body assessment of Resident 1. Staff B stated they only became aware of the bruising because a different investigative authority informed Staff A of the bruising on 09/21/2023.

Interview on 09/22/2023 at 1:54 PM with Staff C, Caregiver, stated that they had not been interviewed by Staff A or other administrative staff regarding the incident (allegation of abuse) on 09/15/2023. Staff C stated that Resident 1 had been telling them for two weeks that a tall man had been entering their room and touching their breast, but that they had not told anyone about the allegations because they were new to working with the resident and was not sure if they had Dementia (memory loss). Staff E also stated that prior to this incident Resident 1 spent most of their time in their room alone but had noticed a recent change in behavior. They stated that Resident 1 had stated they were scared to be alone because a tall man had touched their breasts. Staff C stated that now Resident 1 spent most of their time with other residents in the common area.

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Interview on 09/22/2023 at 2:24 PM with Staff D, Caregiver, stated that on 09/15/2023 they reported to Staff A abuse allegations that had been reported to them by Resident 1. Staff D stated that they had not been asked to write down their statement until 09/22/2023 as they arrived to work that evening shift and prior to speaking on this interview. Staff D stated that they reported to Staff A that Resident 1 had stated to them that on several occasions a tall, skinny man carrying a red jug, wearing a cap and all black had entered their room and touched their breast. Staff C also stated that Resident 1 stated that the unidentified man threatened them that they would return. Staff C stated they observed the bruises on Resident 1's breasts and had taken pictures for another investigative authority but did not report it to Staff A because it was the end of their shift.

Interview on 10/09/2023 at 3:46 PM, Staff B, Caregiver/alleged perpetrator confirmed that they worked from 10:00 PM through 6:00 AM the night of 09/15/2023 (the day after the alleged incident). Staff B also confirmed that they entered Resident 1's place of residence after the alleged allegations unfolded to assist another caregiver providing care to another resident. Staff B stated that they did not feel comfortable re-entering the unit, but that they had been the only float person available that night and needed to assist another caregiver with a two-person resident brief change. Staff B confirmed that they were never told to not enter the house.

Interview on 09/22/2023 at 4:26 PM, Staff A, confirmed that Staff B was allowed to work the rest of their shift and stated that they did not do additional interviews with other residents to see if anyone else had been potentially abused, nor had written statements from staff members who had awareness of the allegations. Staff A acknowledged that they had not completed a thorough investigation that they had "messed up," and felt terrible about it. Staff A stated they did not implement the ALF's abuse investigative procedures because they did not think that the incident had occurred.

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, GUARDIAN ANGEL HOMES (THE COTTAGE) is or will be in compliance with this law and / or regulation on (Date) 10/27/2023

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

V Strawkman
Administrator (or Representative)

10/27/2023
Date

Interview on 09/22/2023 at 4:26 PM, Staff A, confirmed that Staff B was allowed to work the rest of their shift and stated that they did not do additional interviews with other residents to see if anyone else had been potentially abused, nor had written statements from staff members who had awareness of the allegations. Staff A acknowledged that they had not completed a thorough investigation that they had “messed up,” and felt terrible about it. Staff A stated they did not implement the ALFs abuse investigative procedures because they did not think that the incident had occurred.

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