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

ORCHARD CREST LLC
ORCHARD CREST LLC
222 S Evergreen Rd
Spokane Valley, WA 99216

RE: ORCHARD CREST LLC # 1538

Dear Administrator:

This document references Compliance Determination 34469 (01/03/2024), which included complaint number(s) 110852.
The Department completed a complaint investigation of your Assisted Living Facility on 01/03/2024 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Sandra Fast, Community Complaint Investigator

Consultation:

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

There was a reported microwave fire at the facility on December 15th, 2023, at 4:30 PM. This incident was not reported to the Department of Social and Health Services. There was no harm to the resident who accidentally started the fire, and the resident was evacuated from the immediate area. In the future, the facility will report any fires to the Department of Social and Health Services.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

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:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - Whether you want an IDR to occur in-person, by telephone or as a paper review.
  - 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,

S. Jm

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

Residential Care Services
Investigation Summary Report

Provider/Facility: ORCHARD CREST LLC
Provider Type: Assisted Living Facility
License/Cert.#: 1538
Compliance Determination #: 34469
Intake ID: 110852
Investigator: Sandra Fast
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 12/28/2023 through 01/03/2024
Complainant Contact Date(s): 01/05/2024

Allegation(s):

1. A resident had started a fire in their microwave.
2. A resident was given a dose of a medication that had been discontinued.

Investigation Methods:

Sample:
Total residents: 42
Resident sample size: 4
Closed records sample size: 0

Observations:
Staff to resident interactions
Residents in common areas and apartments
Named resident's apartment
Sample residents' apartments
Hallways, corridors and common areas

Interviews:
Named resident's representative
Sample residents
Health Services Coordinator
Residential Care Coordinator
Medication Technician
Maintenance Director

Record Reviews:
Disclosure of services
Characteristic roster
Staff roster
Facility incident report
Fire response plan
Disaster preparedness phone list
Named resident face sheet
Named resident negotiated service agreement
Named resident medication orders
Named resident medication administration records
Sample residents' face sheet
Sample residents' negotiated service agreement
Sample residents medication orders
Sample residents' medication administration records

Investigation Summary:

1. Medication aide was observed using procedures to ensure medications were provided as ordered. Facility had a system for entering orders into the resident medication administration record in a timely manner. Facility system alerted staff when medications were due. Medication administration records showed residents, including named resident received medications as ordered. No failed facility practice was found. 2. Interviews and record reviews showed the facility did not report a fire to the state. Failed practice was identified and a consultation was issued per WAC 388-78a-2650(1).

Conclusion / Action:

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