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 License # 1538

Dear Administrator:

This letter addresses Compliance Determination(s) 62639 (Completion Date 07/17/2025) and 59886 (Completion Date 05/30/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/17/2025 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-2462-2-a, WAC 388-78A-2462-2-b, WAC 388-78A-2462-2

The Department staff who did the on-site verification:
Anne Sinclair, NCI Community Complaint Investigator

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

Sincerely,

Stephanie Jenks, Community 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 #: 59886
Intake ID: 179333
Investigator: Anne Sinclair
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 05/20/2025 through 05/30/2025
Complainant Contact Date(s): 05/16/2025, 05/30/2025

Allegation(s):
1. No facility orientation for agency staff.
2. Dirty facility.
3. Resident fall.
4. Not enough staff for resident care needs.

Investigation Methods:

Sample:
Total residents: 125
Resident sample size: 6
Closed records sample size: 1

Observations:
Residents
Resident rooms
Staff to resident interactions
Resident to resident interactions
Activities
Dining

Interviews:
Residents
Three Resident care coordinators
Three Caregivers
Human Resources staff
Resident Representatives
Collateral Contact
Owner
Director of Care staff

Record Reviews:
Sample resident care plan/face sheet
Facility staff schedule (May 2025)
Disclosure of Services
Characteristic roster
Staff roster

Investigation Summary:
1. Staff interviews and record review showed facility had no consistent facility orientation for agency staff. Facility immediately developed and implemented a plan of correction while investigator was onsite, provided education to all facility and

agency staff on updated information and process for facility orientation. Facility communicated with staffing agency on new staff orientation, resident representatives interviewed had no concerns with care needs. Residents were observed without distress or unmet health needs, and staff were assisting residents during unannounced facility visit. Consultation provided for WAC 388-78A- 2474(2)(a). Sample staff did not have a completed Washington state name and date of birth or federal fingerprint background checks completed. Failed facility practice identified for WAC 388-78A-2462(2)(a)(b).
2. Observation showed facility in good repair, no visual environmental concerns noted during onsite investigation. Resident rooms and common areas were observed clean, no clutter or odors. Facility housekeeping staff were observed active throughout facility, and had an established plan for housekeeping to individual resident apartments. Resident representatives had no concerns with staff response to care needs or housekeeping services. Findings do not support failed facility practice.
3. Facility had a policy for staff to address resident falls, facility had investigated named resident's falls, and had notified appropriate parties. Named resident's representative had no concerns with staff response to care needs, felt resident was safe in facility, and could address concerns with facility staff. Residents were observed without distress or unmet health needs, and staff were assisting residents during unannounced facility visit. Record review showed facility had resident fall precautions and ambulation needs identified in care plan. Findings do not support failed facility practice.
4. Resident representatives interviewed had no concerns with staff response to care needs, had staff to talk to about concerns, and staff were observed active and assisting residents throughout the facility during unannounced facility visit. In an interview the complainant stated they had no direct observation of the resident with unmet care related to staffing levels, and had expressed concern over potential future issues. Facility was actively hiring for care staff, and had employed agency staff in addition to facility staff to address resident care needs. Staff interviewed reported a process to address resident concerns, and had no recent reports from residents for unaddressed resident care. Record review showed facility had staffing scheduled to address all resident locations, and had been updating their agency staff orientation to facility to support competence and continuality with resident care services. Findings do not support failed facility practice.

Conclusion / Action:

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

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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 05/20/2025 and 05/22/2025 of:

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

This document references the following complaint number(s): 179333, 180140

The following sample was selected for review during the unannounced on-site visit: 6 of 125 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Anne Sinclair, NCI Community Complaint Investigator

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

Statement of Deficiencies	License #: 1538	Compliance Determination # 59886
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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 — 06/09/2025 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.

Brandi Peralez — Administrator (or Representative) — 6/13/25 Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

(b) A national fingerprint background check.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure Washington state name and date of birth and national fingerprint background checks were completed for 16 of 16 sampled agency staff (Staff A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, and P). This failure placed residents at risk of having care and services performed by staff who had not been verified appropriately to work with vulnerable adults.

Findings included...

Observation on 05/20/2025 at 11:00 AM, showed two agency staff (staff hired from an outside agency) working with residents as caregivers. Brandi Peralez 6/13/25

Currently Correcting now and hope to be done by 7/10/25

Review of the facility agency staff schedule and agency staff list for May 2025, showed that between 05/01/2025 and 05/31/2025, the facility had utilized 26 agency staff to perform resident care. Brandi Peralez 6/13/25

In interview on 05/27/2025 at 10:30AM, Staff A, Director of Care, stated they were unable to provide completed Washington state name and date of birth and federal Brandi Peralez 6/13/25

Statement of Deficiencies	License #: 1538	Compliance Determination # 59886
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fingerprint background checks for agency staff currently working at the facility. Staff A stated the following agency staff did not have a current Washington state name and date of birth or federal fingerprint background check: Staff A Caregiver, Staff B Caregiver, Staff C Caregiver, Staff D Caregiver, Staff E Caregiver, Staff F Caregiver, Staff G Caregiver, Staff H Caregiver, Staff I Caregiver, Staff J Caregiver, Staff K Caregiver, Staff L Caregiver, Staff M Caregiver, Staff N Caregiver, Staff O Caregiver, and Staff P, Caregiver.

BP 6/13/25

Currently correcting 7/10/25

In an interview on 05/27/2027 at 3:30PM Collateral Contact 1, verified that their staffing agency was unable to complete the Washington state name and date of birth background checks for the facility, and that they did not currently have a fingerprint component to the federal background checks their vendor was running.

Brandi Peralez 6/13/25

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, ORCHARD CREST LLC is or will be in compliance with this law and / or regulation on (Date) 7/10/25 .

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

Brandi Peralez

Administrator (or Representative) Date 6/13/25

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

RE: ORCHARD CREST LLC # 1538

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 05/30/2025 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 any deficiency listed on the enclosed report; and
- May inspect the facility 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 Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Return the Plan/Attestation Statement and report with signatures to:

Stephanie Jenks, Community Field Manager
Residential Care Services

Region 1, Unit B
Preferred methods:
eFax: (509) 921-2426
Email: rcsregion1email@dshs.wa.gov
Optional method:
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• 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-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;

The facility did not have a process for agency staff orientation to facility. The facility immediately developed a plan while investigator was onsite for continuity and communication for agency staff, educated facility staff onsite, and notified staffing agencies they contracted with, related to new process, and updated education for agency staff.

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:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

- Please contact me at (509)993-7821.

Sincerely,

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

Enclosure

Plan of Correction

Facility Name: Orchard Crest Retirement Community

Date PoC Submitted: 6/13/2025

Deficiency Summary

The agency was cited for lack of consistent orientation, incomplete credential tracking, and insufficient oversight of agency staff coverage and accountability.

Corrective Actions Taken

- Orientation Binder Created

A comprehensive Orientation Binder was developed and distributed to all current and new staff. It includes:
- Resident rights
- Emergency procedures
- Abuse prevention
- Infection control
- Agency expectations and more

-Disaster plan

-Emergency numbers

-Standards of conduct and Employee Performance

- Orientation Checklist Implemented

All agency staff must complete and sign a standardized Orientation Checklist as part of onboarding and retraining before working on the floor for the first time.

Med-Techs will have to do an additional MT Orientation Grid. This Grid will need to be completed on the first day of training with Orchard Crest Med Tech. These documents will be kept in each staff file.

- Daily Posted Shift Schedule

A daily shift schedule for agency staff is now posted in a central area. It includes names, roles, assignments, and supervisors.

- Credential Verification Process

All agency staff credentials must be received by scheduler prior to first shift. WA state DSHS background check results and fingerprinting must be received prior to agency staff working first shift. For current agency staff the DSHS background and fingerprints are in the process of be completed soon. No staff are permitted to work without clearance and valid documentation.

- Agency Staff Log Maintained

A Daily Agency Staff Log tracks all agency workers in the building. The log includes:
- Name
- Agency
- Shift scheduled

Preventative Measures

- Orientation Binder and Checklist are mandatory for all staff.
- Credentials will be tracked in a credential log and reviewed monthly.
- These practices are included in training and monitored regularly.

Monitoring and Oversight

- Administrator and HR/Training Coordinator oversee credential files and training compliance.
- Shift Supervisors verify the daily log and enforce the posted schedule.

Corrective actions have now been implemented now and in process

Director of Care Staff Signature

Name: Brandi Peralez

Signature: Brandi Peralez

Date: 6/13/2025