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

Evergreen Fountains LLC
Evergreen Fountains Senior Living Community
1201 North Evergreen Road
Spokane Valley, WA 99216

RE: Evergreen Fountains Senior Living Community License # 1992

Dear Administrator:

This letter addresses Compliance Determination(s) 48742 (Completion Date 10/15/2024) and 45950 (Completion Date 08/22/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/15/2024 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-2466-2, WAC 388-78A-2450-1-a, WAC 388-78A-2140-1-a-iii

The Department staff who did the on-site verification:
Jennifer Lee, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Evergreen Fountains Senior Living Community
Provider Type: Assisted Living Facility
License/Cert.#: 1992
Intake ID: 142463
Compliance Determination #: 45950
Region/Unit #: RCS Region 1 / Unit B
Investigator: Stephanie Jenks
Investigation Date(s): 08/20/2024 through 08/22/2024
Complainant Contact Date(s):

Allegation(s):

1. Monitoring wellbeing of residents
2. Coordination of care
3. Neglect
4. Residents needs not met

Investigation Methods:

Sample:	Total residents: 44 Resident sample size: 4 Closed records sample size: 0
Observations:	AVs Staff response to residents Residents Call lights in AVs rooms
Interviews:	AVs and their POAs Hospice caregivers/nurse Residents Staff
Record Reviews:	AV facesheets, MARs/TARs, prog notes, hospice orders, careplans, assessments, incident reports Staff background checks Staff schedule Call light logs Policy - reporting

Investigation Summary:

1. Identified residents and sampled residents reported that staff take action when they are feeling ill. Staff stated if a resident appears or says they feel sick, they will check their vitals, notify the nurse, contact the resident's emergency contact and will contact 911 if necessary. Resident records showed that staff took action when residents were sick, progress notes showed vitals were taken, providers and families were called and orders requested, and residents were sent to the emergency room for evaluation. No failed practice identified.

2. All staff interviewed stated that if an outside agency such as hospice were involved, they would always call hospice first when a new PRN medication was needed, if hospice had requested a call. Hospice stated they have coordinated with the facility to ensure that staff know when to call them. No failed practice identified.

3. Management stated they have not had any concerns with any staff neglecting residents. Management also stated that residents have not indicated any concerns of neglect. Staff interviewed stated they did not have concerns to report about neglect. Identified residents did not report any concerns of being neglected. Resident representative did not have any concerns of neglect. Outside agency staff did not have any concerns of neglect. Review of sampled staff records, did show that 2 of 3 sampled staff did not have fingerprint background checks conducted. Failed practice identified under WAC 388-78A-2466 (2) Background checks.

4. Care staff interviewed stated that some residents need two caregivers to safely transfer the resident. Management acknowledged that some residents do intermittently require two care staff to safely transfer the resident. Interviewed staff and staff schedules confirmed that only one caregiver is on night shift from 10pm to 6am. Resident service plans did not reflect the higher level of care needed. Failed practice identified under WAC 388-78A-2450 (1) Staffing and WAC 388-78A-2140 (1)(a)(iii) – NSA contents.

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 #: 1992	Compliance Determination # 45950
Plan of Correction	Evergreen Fountains Senior Living Community	Completion Date
Page 1 of 7	Licensee: Evergreen Fountains LLC	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 an unannounced on-site complaint investigation on 08/20/2024 and 08/22/2024 of:

Evergreen Fountains Senior Living Community
1201 North Evergreen Road
Spokane Valley, WA 99216

This document references the following complaint number(s): 142463

The following sample was selected for review during the unannounced on-site visit: 4 of 44 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Stephanie Jenks, Community Field Manager

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

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

08/27/2024
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) Date

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.

(2) A national fingerprint background check is valid for an indefinite period of time. The assisted living facility must ensure there is a valid national fingerprint background check completed for all administrators and caregivers hired after January 7, 2012. To be considered valid, the national fingerprint background check must be initiated and completed through the department's background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to conduct national fingerprint background checks for 2 of 3 sampled staff (Staff A and B). This failure placed residents at risk of receiving care and services from potentially disqualified caregivers.

Findings included...

Review of Staff A's, Nurse Assistant Certified (NAC), personnel file showed they were hired on 01/24/2024. Further review showed the file did not contain a national fingerprint background check.

Review of Staff B's, Nurse Assistant Certified (NAC), personnel file showed they were hired on 02/14/2023. Further review showed the file did not contain a national fingerprint background check.

In an interview on 08/20/2024 at 1:45 PM, Staff D, Administration, confirmed that Staff A and Staff B did not have national fingerprint background checks conducted.

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, Evergreen Fountains Senior Living Community 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) 9.4.24 Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to provide sufficient staffing levels to safely meet the needs of 2 of 4 sampled residents (Resident 1 and 2). This failure placed residents 1 and 2 at risk of harm due to unsafe care practices.

Findings included...

Review of the facility's characteristic roster showed 44 residents resided in the assisted living facility. Further review showed the roster indicated that 20 residents were a "moderate" assist or higher, for assistance with activities of daily living (fundamental, basic self-care tasks that are performed daily).

Review of the August 2024 schedule for caregivers, showed that between 08/01/2024 through 08/20/2024, one caregiver was scheduled for the night shift (10:00 PM to 06:00 AM) for 19 of the 20 shifts.

<Resident 1>

Review of Resident 1's assessment, dated 01/05/2024, showed Resident 1 had a diagnosis of [redacted], and [redacted]. Further review showed that Resident 1 was a "total assist" for toileting and eating and a "max assist" for transfers and dressing.

Review of a physical therapy note, dated 12/11/2023, showed that Resident 1 was at their baseline and therapy recommended "a higher level of care."

In an interview on 08/20/2024 at 1:30 PM, Staff H, Med Tech, stated that Resident 1 often required two caregivers to transfer them. Staff H stated that sometimes they "bearhugged" (method used in which the caregiver will lean forward, squat down, reach

forward around and under the arms of the patient to hug their body and lift them up) Resident 1 but did not feel it was safe to do so. Staff H confirmed that management was made aware of Resident 1's care needs.

In an interview on 08/20/2024, at 1:50 PM, Staff F, Assisted Living Manager, stated that Resident 1 was a "one- to two-person max assist, depending on the day." Staff F stated that it depended on how weak Resident 1 was on a given day that determined if they needed one or two caregivers.

In an interview on 08/20/2024 at 2:50 PM, Staff I, Med Tech, stated that Resident 1 intermittently had days where they needed two caregivers to transfer them. Staff I stated that night shift had one caregiver, and they were unsure of how the night shift caregiver transferred Resident 1 alone.

In an interview on 08/21/2024 at 12:55 PM, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 1 had very high care needs and was not mobile on their own. CC1 stated that Resident 1 needed to be physically lifted and was unsure how staff would transfer them to the toilet. CC1 said they had been present at times when two staff were needed to transfer Resident 1.

<Resident 2>

Review of Resident 2's assessment, dated 12/28/2023, showed Resident 2 was diagnosed with a [redacted], [redacted] ([redacted]), and was on hospice care. Further review showed they were a "max assist" for transfers and a "total assist" for toileting.

In an interview on 08/21/2024, Collateral Contact 2 (CC2), Hospice Registered Nurse, stated that they had observed times when Resident 2 needed two caregivers to transfer them. CC2 stated there were times when they (themselves) had transferred Resident 2 and they became "dead weight." CC2 stated that during the times when Resident 2 was very weak, they did not feel safe transferring Resident 2 alone.

In an interview on 08/22/2024 at 10:50 AM, Staff G, Nurse Assistant Certified, stated that Resident 1 and Resident 2 often required two caregivers to transfer them. Staff G stated they had expressed their concern to management and requested for a lift (equipment used to assist in lifting patients to transfer or provide care) to be provided, and management declined. Staff G stated that at times they had to lift Resident 1 and Resident 2 alone and used the "bearhug" method but did not feel it was safe to do so.

In an interview on 08/22/2024 at 12:00 PM, Staff F stated there was one caregiver on night shift along with a security officer. Staff F confirmed that the security officer was not trained to provide hands on care and did not assist in transfers. When asked how caregivers on night shift safely transferred residents that required a two-person max

assist, Staff F was unable to provide an answer.

In an interview on 08/22/2024 at 12:15 PM, Staff E, Administrator, stated that they preferred not to discharge residents when they declined, and they allowed the residents to "age in place."

In an interview on 08/22/2024 at 3:45 PM, Staff E stated that they agreed there should be two caregivers on site to meet the needs of the residents.

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, Evergreen Fountains Senior Living Community 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) 9.4.24 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;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure the contents of the service agreement aligned with the needs of the resident for 2 of 4 sampled residents (Resident 1 and 2). This failed practice resulted in the residents receiving care that was not safe or consistent with their needs.

Findings included...

<Resident 1>

Review of Resident 1's assessment, dated 01/05/2024, showed Resident 1 had a diagnosis of [redacted], and a history of falls.

Review of Resident 1's Service Plan (the facility's titled negotiated service agreement), dated 01/05/2024, showed that Resident 1 required transfers to be done by a "caregiver assist of one."

In an interview on 08/20/2024 at 1:50 PM, Staff F, Assisted Living Manager, stated that Resident 1 was a "one-to-two-person max assist, depending on the day." Staff F stated that it depended on how weak Resident 1 was feeling on a given day that determined if they needed a two person assist to transfer.

<Resident 2>

Review of Resident 2's assessment, dated 12/28/2023, showed Resident 2 was diagnosed with a [redacted], and was on hospice care. Further review showed they were a "max assist" for transfers and a "total assist" for toileting.

Review of Resident 2's Service Plan, dated 06/18/2024, showed it did not contain directions that hospice needed to be contacted before a PRN (as needed medication) was administered. Further review showed that Resident 2 was a standby assist (requires no more help than standby, cueing or coaxing, without physical contact) and a caregiver assist of one.

In an interview on 08/20/2024 at 12:00 PM, Staff F, stated that some hospice agencies wanted to be contacted prior to PRN medication administrations. Staff F further stated that med techs were to look at the resident service plans (the facility's negotiated service agreements) to determine when hospice was to be notified.

In an interview on 08/21/2024, Collateral Contact 2 (CC2), Hospice Registered Nurse, stated that hospice wanted to be contacted before PRN medications were administered to Resident 2. CC2 further stated that there were times when Resident 2 required two caregivers to transfer them because they were "dead weight".

In an interview on 08/22/2024 at 10:50 AM, Staff G, Nurse Assistant Certified, stated that Resident 2 often required two caregivers to transfer them. Staff G said they had informed management of Resident 2's transfer needs.

In an interview on 08/22/2024 at 3:45 PM, Staff E, Administrator, stated that they

needed to update the service plans to reflect the increased care needs for Resident 1 and Resident 2.

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, Evergreen Fountains Senior Living Community 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: 9.4.24