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 ESTATES RETIREMENT & ASSISTED LIVING COMMUNITY LLC
EVERGREEN ESTATES RETIREMENT & ASSISTED LIVING COMMUNITY
1215 Evergreen Ct
Clarkston, WA 99403

RE: EVERGREEN ESTATES RETIREMENT & ASSISTED LIVING COMMUNITY # 2022

Dear Administrator:

This document references Compliance Determination 28009 (08/22/2023), which included complaint number(s) 92138, 92018.
The Department completed a complaint investigation of your Assisted Living Facility on 08/22/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Joy Pipgras, LTC Surveyor
Mark Sedhom, Assisted Living Facility Licensor

Consultation:

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

Facility failed to update the Negotiated Service Agreement to reflect the needs of sampled residents for fall interventions. New and individualized plans/interventions were needed as the facility had been using the same interventions repeatedly with no assessed outcome. Facility had begun looking at assessments to update the Negotiated Service Agreements at their last QA meetings and were planning on trying new interventions.

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:
  - 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:

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. M

Stephanie Jenks, Field Manager
Region 1, Unit B

Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: EVERGREEN ESTATES RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 2022
Compliance Determination #: 28009
Investigator: Joy Pipgras
Investigation Date(s): 08/17/2023 through 08/22/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 92018
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1. Resident fall with injury leading to death.

Investigation Methods:

Sample:
Total residents: 37
Resident sample size: 4
Closed records sample size: 1

Observations:
Staff presence and interactions with residents
Ombuds/CRU hotline signage
Environment and residents for safety and well-being,
Resident injuries
Pull cords or communication system
Fall hazards
Proper resident footwear
Resident access to mobility devices
Is the facility kept clean and free of clutter/debris

Interviews:
a.) Residents:
Do you feel safe here
Are staff available to assist you- if so how
Do you have someone on staff or outside of the facility you could talk to if you had a concern
Are you aware of the hotline number
Do you have access to an assistive device
Do you have a history of falls

b.) Staff:
How do residents call or ask for help
Do you have access to care plans
What is the policy/procedure/protocol
Who do you notify and how
What is the process for incidents and investigations

Record Reviews:
Characteristic roster
Policy and procedure(s)

Sampled resident's incident reports and investigation
Res progress notes, care plans, face sheet, MARS/TARS and assessments.
Staff list

Investigation Summary:

1.The investigation showed that the named resident had a rapid decline and sustained a fall with no obvious injury but required hospitalization. Sampled residents did not have updated care plans reflecting interventions for residents who had a history of falls. This failure lead sampled residents to have sustained multiple falls. Failed facility practice and identified in a consultation for WAC 388-78A-2130.

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: EVERGREEN ESTATES RETIREMENT & ASSISTED LIVING COMMUNITY
License/Cert.#: 2022
Compliance Determination #: 28009
Investigator: Joy Pipgras
Investigation Date(s): 08/17/2023 through 08/22/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 92138
Region/Unit #: RCS Region 1 / Unit B

Allegation(s):
1. Resident fall with injury.

Investigation Methods:

Sample:
Total residents: 37
Resident sample size: 4
Closed records sample size: 1

Observations:
Staff presence and interactions with residents
Ombuds/CRU hotline signage
Environment and residents for safety and well-being,
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Interviews:
a.) Residents:
Do you feel safe here
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Do you have someone on staff or outside of the facility you could talk to if you had a concern
Are you aware of the hotline number
Do you have access to an assistive device
Do you have a history of falls

b.) Staff:
How do residents call or ask for help
Do you have access to care plans
What is the policy/procedure/protocol
Who do you notify and how
What is the process for incidents and investigations

Record Reviews:
Characteristic roster
Policy and procedure(s)

Sampled resident's incident reports and investigation
Res progress notes, care plans, face sheet, MARS/TARS and assessments.
Staff personnel files

Investigation Summary:

1.The investigation showed that the named resident was independent but sustained a fall with injury that required a higher level of care. The facility followed the plan of care at the time of the incident. Emergent care was provided to the named resident. The facility investigated the fall to rule out abuse or neglect. Sampled residents did not have updated care plans reflecting interventions for residents who had a history of falls, which led to falls with injury. Failed facility practice identified in a consultation for WAC 388-78A-2130 Service agreement planning.

Conclusion / Action:

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